Mission: To improve Medicaid eligibility policy through quality research and collaboration with stakeholders.

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MEPL 94 (Medicaid: Implementing 2101(f)-Like Protection for Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards (10/31/14)
MEM Transmittal Letters

Manual Transmittal Letters (MTLs) are authored by the Medicaid Eligibility Section; they provide a summary of new, revised and/or obsolete policies or rules. MTLs are issued continuously as new regulations, policies and administrative decisions dictate. This letter introduces formal revisions to the Ohio Administrative Code rules and provides instruction of how to maintain the Medicaid Eligibility Manual.
MEMTL 101 (Medicaid: Eligibility Chapter Five)

Medicaid Eligibility Manual Transmittal Letter No. 101

March 25, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility Chapter Five

This MEMTL contains seven new rules from Chapter 5160:1-5 of the Administrative Code, adopted under section 111.15 of the Revised Code. The rules replace seven rescinded rules from the same Chapter. These rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rules is March 23, 2015.

Chapter 5 Special Programs and Services

5160:1-5-01 Breast and cervical cancer project (BCCP)
This rule is rescinded and the language is found in new OAC rule 5160:1-5-02 as part of a five-year rule review.

5160:1-5-02 Breast and cervical cancer project (BCCP) medicaid: definitions
This rule is rescinded and the language is found in new OAC rule 5160:1-5-02.1 as part of a five-year rule review.

5160:1-5-02 Medicaid: breast and cervical cancer project (BCCP)
This rule replaces current rule 5160:1-5-01, but does not make substantive changes.

5160:1-5-02.1 Medicaid: breast and cervical cancer project (BCCP) definitions
This rule replaces current rule 5160:1-5-02, but does not make substantive changes.

5160:1-5-02.2 Medicaid: breast and cervical cancer project (BCCP): eligibility requirements
This rule replaces current rule 5160:1-5-03, but does not make substantive changes.

5160:1-5-02.3 Medicaid: breast and cervical cancer project (BCCP) eligibility period
This rule replaces current rule 5160:1-5-04, but does not make substantive changes.

5160:1-5-02.4 Medicaid: breast and cervical cancer project (BCCP): redetermination process
This rule replaces current rule 5160:1-5-05, but does not make substantive changes.

5160:1-5-03 Medicaid: Breast and cervical cancer project (BCCP) medicaid: eligibility requirements
This rule is rescinded and the language is found in new OAC rule 5160:1-5-02.2 as part of a five-year rule review.

5160:1-5-03 Medicaid: medicaid buy-in for workers with disabilities (MBIWD)
This rule replaces current rule 5160:1-5-30, but does not make substantive changes.

5160:1-5-04 Breast and cervical cancer project (BCCP) medicaid: eligibility period
This rule is rescinded and the language is found in new OAC rule 5160:1-5-02.3 as part of a five-year rule review.

5160:1-5-05 Breast and cervical cancer project (BCCP) medicaid: application process
This rule is rescinded and the language is found in new OAC rule 5160:1-5-02.4 as part of a five-year rule review.

5160:1-5-05 Medicaid: refugee medical assistance (RMA)
This rule replaces current rule 5160:1-6-90, but does not make substantive changes.
**5160:1-5-30 Medicaid: medicaid buy-in for workers with disabilities (MBIWD)**

This rule is rescinded and the language is found in new OAC rule 5160:1-5-03 as part of a five-year rule review.

**5160:1-6-90 Refugee medical assistance (RMA)**

This rule is rescinded and the language is found in new OAC rule 5160:1-5-05 as part of a five-year rule review.

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MEMTL 100 (Medicaid: Eligibility Chapter 4)

Medicaid Eligibility Manual Transmittal Letter No. 100

March 25, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility Chapter 4

This MEMTL contains two rules from Chapter 5160:1-4 of the Administrative Code, adopted under section 111.15 of the Revised Code. These rules replace eight rescinded rules from Chapters 5160:1-4 and 5160:1-6. Rescinded rule 5160:1-4-03 was reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rules is March 26, 2015.

Chapter 4 Covered Families and Children (CFC)

5160:1-4-02.1 Medicaid: coverage for families.

This rule is rescinded because low-income families Medicaid has been replaced by MAGI-based Medicaid, as described in rule 5160:1-1-65.

5160:1-4-02.2 Medicaid: coverage for children.

This rule is rescinded because the Medicaid eligibility criteria for children has been replaced by the MAGI-based Medicaid eligibility criteria for children younger than age nineteen, as described in rule 5160:1-1-63.

5160:1-4-02.3 Medicaid: coverage for pregnant women.

This rule is rescinded because the Medicaid eligibility criteria for pregnant women has been replaced by the MAGI-based Medicaid eligibility criteria for pregnant women, as described in rule 5160:1-1-64.

5160:1-4-02.4 Medicaid: coverage for individuals at least age nineteen and younger than age twenty-one.

This rule is rescinded because the Medicaid eligibility criteria for individuals at least age nineteen and younger than age twenty-one has been replaced by the MAGI-based Medicaid eligibility criteria for individuals at least age nineteen and younger than age twenty-one, as described in rule 5160:1-1-63.1.

5160:1-4-03 Medicaid: children in care and individuals younger than age twenty-one who have aged out of foster care.

This rule is rescinded as part of the five-year rule review because the Medicaid eligibility criteria for children in care and individuals younger than age twenty-one who have aged out of foster care has been replaced by the MAGI-based Medicaid eligibility criteria for children in care and former foster care adults, as described in rules 5160:1-1-63 and 5160:1-1-63.1, respectively.

5160:1-4-20 Medicaid: low-income families, children, and pregnant women budgeting.

This rule is rescinded because the Medicaid budgeting methodology for low-income families, children, and pregnant women has been replaced by the MAGI-based Medicaid budgeting methodology, as described in rule 5160:1-1-61.

5160:1-4-02 MAGI-based medicaid: coverage for children younger than age nineteen.

This new rule replaces current rule 5160:1-1-63, adds clarifying language, and updates rule references.

5160:1-4-03 MAGI-based medicaid: coverage for Ribicoff and former foster care adults.

This new rule replaces current rule 5160:1-1-63.1, adds clarifying language, and updates rule references.

Chapter 6 Medicaid Eligibility Modernization

5160:1-1-63 MAGI-based medicaid: coverage for children younger than age nineteen.
This rule is rescinded and renumbered as new rule 5160:1-4-02 to clarify policy relating to administration of the Medicaid program and update rule references.

**5160:1-1-63.1** MAGI-based medicaid: coverage for Ribicoff and former foster care adults.

This rule is rescinded and renumbered as new rule 5160:1-4-03 to clarify policy relating to administration of the Medicaid program and update rule references.

**MEM Instructions:**

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MEMTL 99 (Medicaid: Application for Home and Community-Based [HCB] Services)

Medicaid Eligibility Manual Transmittal Letter No. 99

March 25, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Application for Home and Community-Based (HCB) Services

This MEMTL contains one new rule from Chapter 5160:1-2 of the Administrative Code, adopted under section 111.15 of the Revised Code. The rule replaces one rescinded rule from the same Chapter. These rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rule is March 23, 2015.

Chapter 2 Application Processing

5160:1-2-01.6 Medicaid: application for home and community-based (HCB) services

This rule is rescinded and the language is found in new OAC rule 5160:1-2-03 as part of a five-year rule review.

5160:1-2-03 Medicaid: application for home and community-based (HCB) services

This rule replaces current rule 5160:1-2-01.6, but does not make substantive changes.

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MEMTL 98 (Medicaid: Eligibility through the Spenddown Process)

Medicaid Eligibility Manual Transmittal Letter No. 98

March 27, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility through the Spenddown Process

The rule in this transmittal has been updated as part of five-year review in accordance with section 119.032 of the Revised Code. The rule is renumbered as part of an overall reorganization of the Medicaid eligibility rules, citations to the Ohio Administrative Code, Code of Federal Regulations, and United States Code are updated, and many minor changes are made for clarity and consistency; however, there are no substantive policy changes.

The effective date of the rules is April 1, 2015.

Chapter 3

5160:1-3-04.1 Medicaid: Eligibility through the Spenddown Process

This rule is replacing rule 5160:1-3-10, which is being rescinded and made new under this new rule number because of five-year review and as part of the reorganization of this chapter in the MEM. It sets forth the spenddown process, through which an individual seeking coverage as an aged, blind or disabled individual, who meets all Medicaid eligibility criteria other than the income test, can qualify for coverage for one or more months.

The new rule implements no substantive policy changes, but it is completely restructured for clarity, better organization, and consistency with other rules. Other changes to the rule consist of removal of redundant language, renumbering of Administrative Code citations, and minor changes for clarity and correctness.

5160:1-3-10 Medicaid: Eligibility Through the Spenddown Process

This rule is being rescinded and made new with a new rule number, as described in the preceding paragraph.

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MEMTL 97 (Medicaid: DDA Process Rule)
Medicaid Eligibility Manual Transmittal Letter No. 97
March 3, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: DDA Process Rule

The rules included in this transmittal have been updated as part of five-year review in accordance with section 119.032 of the Revised Code. The rules are renumbered as part of an overall reorganization of the Medicaid eligibility rules, citations to the Ohio Administrative Code, Code of Federal Regulations, and United States Code are updated, and many minor changes are made for clarity and consistency; however, there are no substantive policy changes.

The effective date of the rules is February 23, 2015.

**Chapter 3 Aged, Blind and Disabled (ABD)**

5160:1-3-02.9 Medicaid: disability determination process

This new rule replaces the disability determination process language from the former rule 5160:1-3-02, which was rescinded under another rule package. This new rule does not make any policy changes. Rule language is clarified and reorganized, references to JFS are changed to ODM, references to CMS are changed to DDA, and other minor changes are made where appropriate.

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MEMTL 96 (Medicaid: Pregnancy Related Services [PRS])

Medicaid Eligibility Manual Transmittal Letter No. 96

January 15, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Pregnancy Related Services (PRS)

The rule included in this transmittal has been updated as part of a five-year review in accordance with section 119.032 of the Revised Code.

The effective date of this rule is January 1, 2015.

Chapter 5 Special Programs and Services

5160:1-2-06 Medicaid: Pregnancy Related Services (PRS)

This rule is rescinded and renumbered as new rule 5160:1-2-16 as part of five-year rule review.

5160:1-2-16 Medicaid: Pregnancy Related Services (PRS)

This rule replaces rule 5101:1-2-06, setting forth the policy and practice for the county department of job and family services' administrative responsibilities for the implementation of Pregnancy Related Services for Medicaid-eligible pregnant women.

Specific changes to the rule include:

- Reorganized and rewritten for clarity of language
- Removal of several definitions that can be found in current rule 5160:1-1-50.1
- Removal of reference to JFS 08062 "Healthy Start for a Healthy Baby" brochure
- Removal of reference to the quarterly data collection reports
- Replaced reference to Local Program Management Description with new form ODM 03515 "Pregnancy Related Services Implementation Plan".

Form

ODM 03515 Pregnancy Related Services Implementation Plan

The ODM 03515 "Pregnancy Related Services Implementation Plan" (PRSIP) replaces the Local Program Management Description (LPMD). The ODM 03515 shall be the required form for submission. The ODM 03515 is referenced in and required by Administrative Code rule 5160:1-2-16.

ODM 03515-I Instructions for Completing the Pregnancy Related Services Implementation Plan

Instructions provide guidance for completing the ODM 03515.

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MEMTL 95 (Medicaid: Eligibility Chapter 2)
Medicaid Eligibility Manual Transmittal Letter No. 95
January 15, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility Chapter 2

This MEMTL contains one new rule from Chapter 5160:1-2 of the Administrative Code, adopted under section 111.15 of the Revised Code. The rule replaces one rescinded rule from the same Chapter and nine other rules are being rescinded. These rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective dates of the rules are January 15, 2015.

Chapter 2 Application Processing

5160:1-2-01 Medicaid: individual and administrative agency responsibilities
This rule is rescinded and the language is found in current OAC rule 5160:1-1-51 as part of a five-year rule review.

5160:1-2-01.2 Medicaid: application, determination, and redetermination processes
This rule is rescinded and the language is found in current OAC rule 5160:1-1-51 as part of a five-year rule review.

5160:1-2-01.7 Medicaid: assisting individuals unable to access verifications due to physical or mental impairment
This rule is rescinded and the language is found in current OAC rule 5160:1-1-51 as part of a five-year rule review.

5160:1-2-01.8 Medicaid: conditions of eligibility for each applicant or recipient
This rule is rescinded and the language is found in current OAC rule 5160:1-1-58 as part of a five-year rule review.

5160:1-2-02 Medicaid: United States (U.S.) citizenship documentation
This rule is rescinded and the language is found in current OAC rule 5160:1-1-58.2 as part of a five-year rule review.

5160:1-2-02.3 Medicaid: qualified aliens
This rule is rescinded and the language is found in current OAC rule 5160:1-1-58.3 as part of a five-year rule review.

5160:1-2-07 Medicaid: estate recovery
This rule replaces current rule 5160:1-2-10, but does not make substantive changes.

5160:1-2-10 Medicaid: estate recovery
This rule is rescinded and the language is found in new OAC rule 5160:1-2-07 as part of a five-year rule review.

5160:1-2-20 Medicaid: consumer fraud and erroneous payments
This rule is rescinded and the language is found in current OAC rule 5160:1-1-51.2 as part of a five-year rule review.

5160:1-2-40 Medicaid: presumptive eligibility for children younger than age nineteen
This rule is rescinded and the language is found in current OAC rule 5160:1-1-62 as part of a five-year rule review.

5160:1-2-50 Medicaid: presumptive eligibility for pregnant women

This rule is rescinded and the language is found in current OAC rule 5160:1-1-62 as part of a five-year rule review.

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MEMTL 94 (Medicaid: Eligibility Chapter 1)

Medicaid Eligibility Manual Transmittal Letter No. 94
January 15, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility Chapter 1

This MEMTL contains one new rule from Chapter 5160:1-1 of the Administrative Code, adopted under section 111.15 of the Revised Code. The rule replaces one rescinded rule from the same Chapter and three other rules are being rescinded. These rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective dates of the rules are January 15, 2015.

**Chapter 1 Introduction to Medicaid Policy**

**5160:1-1-01.1 Medicaid: safeguarding and releasing information**

This rule is rescinded and the language is found in current OAC rule 5160:1-1-51.1 as part of a five-year rule review.

**5160:1-1-03.1 Medicaid: income and eligibility verification system (IEVS)**

This rule is rescinded and the language is found in new rule OAC rule 5160:1-1-04 as part of a five-year rule review.

**5160:1-1-04 Medicaid: income and eligibility verification system (IEVS)**

This rule replaces current rule 5160:1-1-03.1, but does not make substantive changes.

**5160:1-1-20 Medicaid: restrictions on payment of services**

This rule is rescinded and the language is found in current OAC rule 5160:1-1-58.1 as part of a five-year rule review.

**Chapter 3 Aged, Blind, and Disabled (ABD)**

**5160:1-1-04 Medicaid: replacement checks**

This rule is rescinded as part of a five-year review and to remove process from the rules.

**MEM Instructions:**

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MEMTL 93 (Medicaid: Special Income Level)

Medicaid Eligibility Manual Transmittal Letter No. 93
February 11, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Special Income Level

The rules included in this transmittal have been updated as part of five-year review in accordance with section 119.032 of the Revised Code. The rules are renumbered as part of an overall reorganization of the Medicaid eligibility rules, citations to the Ohio Administrative Code, Code of Federal Regulations, and United States Code are updated, and many minor changes are made for clarity and consistency; however, there are no substantive policy changes.

The effective date of the rules is February 1, 2015.

Chapter 3 Aged, Blind and Disabled (ABD)

Medicaid: 5160:1-3-04.2 Income Computations for Determining Eligibility Using the Special Income Level

This new rule replaces current rule 5160:1-3-23, which is being rescinded as part of five-year rule review. The new rule defines how income is computed and compared to the special income level for purposes of determining eligibility for Medicaid coverage of long term care services in a long term care facility, under a home and community-based services (HCBS) waiver program, or under the program of all-inclusive care for the elderly (PACE).

Changes to the rule consist of removal of redundant language, renumbering of Administrative Code citations, and minor changes for clarity and consistency with other rules.

Medicaid: 5160:1-3-23 Income Computations for Determining Eligibility Using the Special Income Level

This rule is rescinded and renumbered as new rule 5160:1-3-04.2 as part of five-year rule review.

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MEMT 92 (Medicaid: ABD Five-Year Review Batch Five)

Medicaid Eligibility Manual Transmittal Letter No. 92

January 15, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: ABD Five-Year Review Batch Five

This MEMTL contains five new rules from Chapter 5160:1-3 of the Administrative Code, adopted under section 111.15 of the Revised Code. These rules replace five rescinded rules from the same Chapter. These rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective dates of the rules are January 15, 2015.

Chapter 3 Aged, Blind and Disabled (ABD)

5160:1-3-05 Medicaid: resource requirement
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.1 as part of a five-year rule review.

5160:1-3-05.1 Medicaid: resource requirement
This rule replaces current rule 5160:1-3-05, but does not make substantive changes.

5160:1-3-05.2 Medicaid: trusts
This rule replaces current rule 5160:1-3-27.1. Changes to the rule include adding language on the rule's enforceability to the same extent as Revised Code 5163.21.

5160:1-3-05.3 Medicaid: the disclosure and treatment of annuities for recipients or applicants for medical assistance programs
This rule replaces current rule 5160:1-3-22.8. Changes made to the rule include the removal of some language on the treatment of annuities purchased prior to February 8, 2006 and replacing references to the C.F.R. with references to OAC rule 5160:1-3-05.17.

5160:1-3-06 Medicaid: social security administration reporting alleged transfer of resources by supplemental security income (SSI) applicants to the Ohio department of job and family services
This rule is rescinded and the language is found in new OAC rule 5160:1-3-07.1 as part of a five-year rule review.

5160:1-3-07.1 Medicaid: disposal of resources for Ohio department of mental retardation and developmental disabilities and/or Ohio department of mental health assistance groups
This rule is rescinded and the language is found in new OAC rule 5160:1-3-07.3 as part of a five-year rule review.

5160:1-3-07.1 Medicaid: social security administration reporting alleged transfer of resources by supplemental security income (SSI) applicants to the Ohio department of Medicaid
This rule replaces current rule 5160:1-3-06, but does not make substantive changes.

5160:1-3-07.3 Medicaid: disposal of resources for Ohio department of developmental disabilities and/or Ohio department of mental health and addiction services individuals
This rule replaces current rule 5160:1-3-07.1, but does not make substantive changes.

5160:1-3-22.8 Medicaid: the disclosure and treatment of annuities for recipients or applicants for medical assistance programs
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.3 as part of a five-year rule review.
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.2 as part of a five-year rule review.

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MEMTL 91 (Medicaid: ABD Income Rules)

Medicaid Eligibility Manual Transmittal Letter No. 91

February 11, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: ABD Income Rules

The rules included in this transmittal have been updated as part of five-year review in accordance with section 119.032 of the Revised Code. The rules are renumbered as part of an overall reorganization of the Medicaid eligibility rules, citations to the Ohio Administrative Code, Code of Federal Regulations, and United States Code are updated, and many minor changes are made for clarity and consistency. Only one rule contains policy changes, as described below.

The effective date of the rules is February 1, 2015.

Chapter 3 Aged, Blind and Disabled (ABD)

5160:1-3-02.1 Medicaid: treatment of social security payments made to certain persons who are made ineligible for SSI due to such payments

This rule is rescinded and renumbered as new rule 5160:1-3-03.2 as part of five-year rule review.

5160:1-3-03.1 Medicaid: income
This new rule replaces current rule 5160:1-3-08, but does not make any policy changes.

5160:1-3-03.2 Medicaid: treatment of social security payments made to certain individuals who are made ineligible for SSI due to such payments
This new rule replaces current rule 5160:1-3-02.1, with numerous small changes made for clarity and correctness, but no substantive policy changes.

5160:1-3-03.3 Medicaid: sheltered workshop earnings
This new rule replaces current rule 5160:1-3-14.4, but does not make any policy changes.

5160:1-3-03.5 Medicaid: need standards
This new rule replaces current rule 5160:1-3-21. It was extensively rewritten for clarity and brevity, but no policy changes were made.

5160:1-3-03.6 Medicaid: treatment of rental income
This new rule replaces current rule 5160:1-3-15.1, but does not make any policy changes.

5160:1-3-03.7 Medicaid: treatment of sick pay
This new rule replaces current rule 5160:1-3-15.2, but does not make any policy changes.

5160:1-3-03.8 Medicaid: in-kind support and maintenance
This new rule replaces current rule 5160:1-3-17, but does not make any policy changes.

5160:1-3-03.9 Medicaid: deeming of income
This new rule replaces current rule 5160:1-3-19, but does not make any policy changes.

5160:1-3-03.10 Medicaid: retirement and income supplementing accounts (RISAs)
This new rule replaces current rule 5160:1-3-22.7, but does not make any policy changes.

5160:1-3-03.11 Medicaid: Income Exemptions and Disregards
This new rule replaces current rule 5160:1-3-18. It was extensively rewritten to align with federal statute. Specifically, the new rule sets forth the correct order in which income exemptions and disregards must be
subtracted from the individual’s budget, removes some exemptions that have become obsolete due to changes in federal law, and removes redundant and contradictory language.

5160:1-3-08 Medicaid: income
This rule is rescinded and renumbered as new rule 5160:1-3-03.1 as part of five-year rule review.

5160:1-3-14.4 Medicaid: sheltered workshop earnings
This rule is rescinded and renumbered as new rule 5160:1-3-03.3 as part of five-year rule review.

5160:1-3-15.1 Medicaid: treatment of rental income
This rule is rescinded and renumbered as new rule 5160:1-3-03.6 as part of five-year rule review.

5160:1-3-15.2 Medicaid: treatment of sick pay
This rule is rescinded and renumbered as new rule 5160:1-3-03.7 as part of five-year rule review.

5160:1-3-17 Medicaid: in-kind support and maintenance
This rule is rescinded and renumbered as new rule 5160:1-3-03.8 as part of five-year rule review.

5160:1-3-18 Medicaid: income exemptions and disregards
This rule is rescinded and renumbered as new rule 5160:1-3-03.11 as part of five-year rule review.

5160:1-3-19 Medicaid: deeming of income
This rule is rescinded and renumbered as new rule 5160:1-3-03.9 as part of five-year rule review.

5160:1-3-21 Medicaid: standards and allocations
This rule is rescinded and renumbered as new rule 5160:1-3-03.5 as part of five-year rule review.

5160:1-3-22.7 Medicaid: retirement and income supplementing accounts (RISAs)
This rule is rescinded and renumbered as new rule 5160:1-3-03.10 as part of five-year rule review.

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MEMTL 90 (Medicaid: ABD Base Eligibility Rules)

Medicaid Eligibility Manual Transmittal Letter No. 90
February 5, 2015

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: ABD base eligibility rules

The rules included in this transmittal have been updated as part of five-year review in accordance with section 119.032 of the Revised Code. The rules are renumbered as part of an overall reorganization of the Medicaid eligibility rules, citations to the Ohio Administrative Code, Code of Federal Regulations, and United States Code are updated, and many minor changes are made for clarity and consistency; however, there are no substantive policy changes.

The effective date of the rules is January 22, 2015.

Chapter 3 Aged, Blind and Disabled (ABD)

5160:1-2-03 Medicare buy-in
This rule is rescinded and renumbered as new rule 5160:1-3-02.6 as part of five-year rule review.

5160:1-3-01 Medicaid: Aged, Blind, and Disabled
This new rule provides a brief overview of the organization of the ABD Medicaid rules.

5160:1-3-01.1 Medicare premium assistance programs (MPAP)
This rule is rescinded and renumbered as new rule 5160:1-3-02.1 as part of five-year rule review.

5160:1-3-01.2 Medicare: qualified disabled and working individuals (QDWI)
This rule is rescinded and renumbered as new rule 5160:1-3-02.2 as part of five-year rule review.

5160:1-3-02 Medicaid: grandfathering provisions resulting from the implementation of the supplemental security income (SSI) program
This rule is rescinded and renumbered as new rule 5160:1-3-02.3 as part of five-year rule review.

5160:1-3-02.1 Medicare premium assistance programs (MPAP)
This new rule replaces current rule 5160:1-3-01.1, but does not make substantive changes.

5160:1-3-02.2 Medicare: qualified disabled and working individuals (QDWI)
This new rule replaces current rule 5160:1-3-01.2, but does not make substantive changes.

5160:1-3-02.3 Medicaid: SSI recipients qualifying under section 1619 of the Social Security Act for continued medicaid coverage
This rule is rescinded and renumbered as new rule 5160:1-3-02.4 as part of five-year rule review.

5160:1-3-02.3 Medicare: grandfathering provisions resulting from the implementation of the supplemental security income (SSI) program
This new rule replaces current rule 5160:1-3-02, but does not make substantive changes.

5160:1-3-02.4 Medicaid: SSI recipients qualifying under section 1619 of the Social Security Act for continued medicaid coverage
This new rule replaces current rule 5160:1-3-02.3, but does not make substantive changes.
5160:1-3-02.6 Medicare buy-in
This new rule replaces current rule 5160:1-2-03, but does not make substantive changes.

5160:1-3-03 Medicaid: limiting physical factor
This rule is rescinded and its provisions are incorporated into new rule 5160:1-3-02 as part of five-year rule review.

5160:1-3-03.4 Medicaid: continued medicaid coverage for children who lost their eligibility for supplemental security income (SSI) due to a change in the disability determination
This rule is rescinded as part of five-year rule review.

5160:1-3-04 Medicaid: living arrangement requirement
This rule is rescinded as part of five-year rule review, as it was duplicative: the information in this rule was already in rules 5160:1-1-58 and 5160:1-1-58.1.

5160:1-3-11 Medicaid eligibility for persons living in state institutions for the mentally ill and mentally retarded
This rule is rescinded and its provisions are incorporated into new rule 5160:1-3-02 as part of five-year rule review.

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MEMTL 89 (Medicaid: Treatment of Qualified Long-Term Care Insurance Policies)

Medicaid Eligibility Manual Transmittal Letter No. 89
December 10, 2014

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Treatment of Qualified Long-Term Care Insurance Policies

This MEMTL contains one rescinded rule from Chapter 5160:1-2 of the Administrative Code, and one new rule from Chapter 5160:1-3 of the Administrative Code. These rules are part of a five-year rule review and were also reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rescission of the old rule and the implementation of the new rule is December 1, 2014.

Chapter 2
Medicaid: 5160:1-2-11 Treatment of Qualified Long-Term Care Insurance Policies

This rule is being rescinded and made new with a new rule number as part of an extensive reorganization of the Medicaid eligibility rules.

This rule describes the qualified long-term care partnership (QLTCP) program under which an individual's resources are disregarded in eligibility determinations and at estate recovery in the amount of benefits paid to or on behalf of the consumer by a QLTCP policy.

Chapter 3
Medicaid: 5160:1-3-02.8 Treatment of Qualified Long-Term Care Insurance Policies

This rule is replacing rule 5160:1-2-11, which is being rescinded and made new with this new rule number as part of an extensive reorganization of the Medicaid eligibility rules.

There are no policy changes being made to this rule at this time. Changes are: updated OAC and ORC citations, removal of redundant language, and changes made for clarity, brevity, correctness and consistency with other rules.

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MEMTL 88 (Medicaid: ABD Five-Year Review Batch Three)

Medicaid Eligibility Manual Transmittal Letter No. 88

October 31, 2014

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: ABD Five-Year Review Batch Three

This MEMTL contains nine new rules from Chapter 5160:1-3 of the Administrative Code, adopted under section 111.15 of the Revised Code. These rules replace nine rescinded rules from the same Chapter. These rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective dates of the rules are November 3, 2014).

Chapter 3 Aged, Blind and Disabled (ABD)

5160:1-3-05.16 Medicaid: home replacement exclusion
This rule replaces current rule 5160:1-3-31.4, but does not make substantive changes.

5160:1-3-05.17 Medicaid: life estates and life leases
This rule replaces current rule 5160:1-3-32, but does not make substantive changes.

5160:1-3-05.19 Medicaid: real or personal property essential for self-support
This rule replaces current rule 5160:1-3-33, but does not make substantive changes.

5160:1-3-05.20 Medicaid: deeming of resources
This rule replaces current rule 5160:1-3-34, but does not make substantive changes.

5160:1-3-06.1 Medicaid: treatment of income and resources of institutionalized individuals
This rule replaces current rule 5160:1-3-22, but does not make substantive changes.

5160:1-3-06.2 Medicaid: resource assessment
This rule replaces current rule 5160:1-3-35, but does not make substantive changes.

5160:1-3-06.3 Medicaid: treatment of resources for institutionalized individuals with a spouse in the community
This rule replaces current rule 5160:1-3-36, but does not make substantive changes.

5160:1-3-06.4 Medicaid: resource budgeting methodology for institutionalized individuals with a spouse in the community
This rule replaces current rule 5160:1-3-36.1, but does not make substantive changes.

5160:1-3-06.5 Medicaid: transfer of resources for institutionalized spouses with a spouse in the community
This rule replaces current rule 5160:1-3-36.2, but does not make substantive changes.

5160:1-3-22 Medicaid: treatment of income and resources of institutionalized individuals
This rule is rescinded and the language is found in new OAC rule 5160:1-3-06.1 as part of a five-year rule review.

5160:1-3-31.4 Medicaid: home replacement exclusion
This rule is rescinded and language is found in new OAC rule 5160:1-3-05.16 as part of a five-year rule review.

5160:1-3-32 Medicaid: Life Estates and Life Leases
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.17 as part of a five-year rule review.

5160:1-3-33 Real or personal property essential to self-support
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.19 as part of a five-year rule review.

5160:1-3-34 Deeming of resources
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.20 as part of a five-year rule review.

5160:1-3-35 Medicaid: resource assessment
This rule is rescinded and the language is found in new OAC rule 5160:1-3-06.2 as part of a five-year rule review.

5160:1-3-36 Medicaid: treatment of resources for institutionalized individuals with a spouse in the community
This rule is rescinded and the language is found in new OAC rule 5160:1-3-06.3 as part of a five-year rule review.

5160:1-3-36.1 Medicaid: resource budgeting methodology for institutionalized individuals with a spouse in the community
This rule is rescinded and the language is found in new OAC rule 5160:1-3-06.4 as part of a five-year rule review.

5160:1-3-36.2 Medicaid: transfer of resources for institutionalized individuals spouses with a spouse in the community
This rule is rescinded and the language is found in new OAC rule 5160:1-3-06.5 as part of a five-year rule review.

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MEMTL 87 (Medicaid: ABD Five-Year Review Batch One)

Medicaid Eligibility Manual Transmittal Letter No. 87

October 3, 2014

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: ABD Five-Year Review Batch One

This MEMTL contains twelve new rules from Chapter 5160:1-3 of the Administrative Code, adopted under section 111.15 of the Revised Code. These rules replace twelve rescinded rules from the same Chapter. These rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective dates of the rules are October 2, 2014.

Chapter 3 Aged, Blind and Disabled (ABD)

5160:1-3-05.4 Medicaid: cash and checking and savings accounts and time deposits
This rule replaces current rule 5160:1-3-27.2, but does not make substantive changes.

5160:1-3-05.5 Medicaid: promissory notes, mortgages, stocks, bonds and loans
This rule replaces current rule 5160:1-3-27.3, but does not make substantive changes.

5160:1-3-05.6 Medicaid: preneed funeral contracts
This rule replaces current rule 5160:1-3-27.4, but does not make substantive changes.

5160:1-3-05.7 Medicaid: burial spaces
This rule replaces current rule 5160:1-3-32.2, but does not make substantive changes.

5160:1-3-05.8 Medicaid: lump-sum payments
This rule replaces current rule 5160:1-3-27.5, but does not make substantive changes.

5160:1-3-05.9 Medicaid: dividends and interest
This rule replaces current rule 5160:1-3-27.6, but does not make substantive changes.

5160:1-3-05.10 Medicaid: household goods and personal effects as resources
This rule replaces current rule 5160:1-3-28, but does not make substantive changes.

5160:1-3-05.11 Medicaid: automobiles and other modes of transportation as resources
This rule replaces current rule 5160:1-3-29, but does not make substantive changes.

5160:1-3-05.12 Medicaid: life insurance
This rule replaces current rule 5160:1-3-30, but does not make substantive changes.

5160:1-3-05.13 Medicaid: treatment of the home
This rule replaces current rule 5160:1-3-31, but does not make substantive changes.

5160:1-3-05.14 Medicaid: resource exemption
This rule replaces current rule 5160:1-3-26, but does not make substantive changes.

5160:1-3-05.15 Medicaid: exemption of property no longer the principal place of residence
This rule replaces current rule 5160:1-3-31.3, but does not make substantive changes.

5160:1-3-26 Medicaid: resource exemption
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.14 as part of a five-year rule review.
5160:1-3-27.2 Medicaid: cash and checking and savings accounts and time deposits
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.4 as part of a five-year rule review.

5160:1-3-27.3 Medicaid: promissory notes, mortgages, stocks, bonds and loans
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.5 as part of a five-year rule review.

5160:1-3-27.4 Medicaid: preneed funeral contracts
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.6 as part of a five-year rule review.

5160:1-3-27.5 Medicaid: lump-sum payments
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.8 as part of a five-year rule review.

5160:1-3-27.6 Medicaid: dividends and interest
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.9 as part of a five-year rule review.

5160:1-3-28 Household goods and personal effects as resources
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.10 as part of a five-year rule review.

5160:1-3-29 Automobiles and other modes of transportation as resources
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.11 as part of a five-year rule review.

5160:1-3-30 Medicaid: life insurance
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.12 as part of a five-year rule review.

5160:1-3-31 Medicaid: treatment of the home
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.13 as part of a five-year rule review.

5160:1-3-31.3 Medicaid: exemption of property no longer the principal place of residence
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.15 as part of a five-year rule review.

5160:1-3-32.2 Medicaid: burial spaces
This rule is rescinded and the language is found in new OAC rule 5160:1-3-05.7 as part of a five-year rule review.

**MEM Instructions:**

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MEMTTL 86 (Medicaid: Life Estates and Life Leases)

Medicaid Eligibility Manual Transmittal Letter No. 86

October 29, 2013

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Life Estates and Life Leases

This rule contained an incorrect citation, which was leading workers to an incorrect table for the valuation of life estates and remainder interests.

The effective date of this rule is November 1, 2013.

Chapter 3 - Aged, Blind and Disabled (ABD)


The rule is amended as follows: the incorrect citation in paragraph (F) is removed, and the correct life estate and remainder interest valuation table, as provided by CMS in the State Medicaid Manual, is inserted into the rule. All other changes are minor, and are made for clarification and consistency with current rule-writing conventions. This amendment is simply a clarification of policy and practice; there is no policy change.

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MEMTL 85 (Medicaid: Determining Patient Liability)

Medicaid Eligibility Manual Transmittal Letter No. 85

October 18, 2013

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Determining Patient Liability

The court order ending the Ledford v. Colbert lawsuit requires the state to change the way veterans' Aid and Attendance pension income is treated when calculating patient liability for HCBS waiver cases.

This MEMTL contains one amended rule from Chapter 5101:1-39 of the Administrative Code, adopted under section 111.15 of the Revised Code and reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the amended rule is November 1, 2013.

Chapter 3


The Aid and Attendance pension is an enhanced or special monthly pension benefit that the Veterans Administration (VA) pays in addition to the basic pension. The VA pays Aid and Attendance to a veteran who needs assistance with activities of daily living, is bedridden, is a patient in a nursing home, or is blind, or to the veteran's surviving spouse who meets the same criteria. When such a veteran who has no spouse or dependent minor or disabled child is institutionalized in a nursing facility, the VA reduces the individual's total pension to ninety dollars.

Under the old policy, the VA Aid and Attendance pension was treated differently for veterans receiving HCBS waiver services versus veterans in a nursing facility: it was considered countable income in patient liability calculations for veterans who were receiving HCBS waiver services, but was excluded as income in patient liability calculations for veterans in a Title XIX nursing facility.

The new policy treats VA Aid and Attendance pensions similarly for veterans receiving HCBS waiver services and veterans in a nursing facility:

- The first ninety dollars of VA Aid and Attendance pension is to be excluded as income in patient liability calculations for veterans or their widows who are receiving HCBS waiver services and who have no dependent minor or disabled children, and
- The VA Aid and Attendance ninety-dollar reduced pension paid to a veteran in a Title XIX nursing facility will continue to be excluded as income in patient liability calculations.

These changes first became effective October 1, 2012 with the issuance of MEPL 66, and continue with the issuance of this amended rule.

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Ohio has changed its deeming methodology for ABD cases so that it aligns with federal guidelines found in the Social Security Administration’s Program Operations Manual System (POMS). This rule was reviewed in accordance with section 119.032 of the Revised Code.

The effective date of this rule is March 1, 2013.

Chapter 3

Medicaid: \textbf{5101:1-39-19} Deeming of Income

Specific changes to the rule include:

- Rewritten for clarity, including the removal of redundant language
- A revised list of exempt income types; list is taken from POMS
- Removal of all references to the deeming worksheet
- Ineligible person allocation is changed: instead of being a static $163, it will now change with the current SSI Federal Benefit Rate (FBR). The allocation amount is now the current FBR for couples minus the current FBR for individuals.
- For spouse-to-spouse deeming, the eligible spouse’s income (after deeming) is compared to the Medicaid need standard for couples rather than to the Medicaid need standard for an individual.

Until CRIS-E is reprogrammed to calculate deeming in accordance with the amended rule, workers need to use the ABD deeming calculator, which is available on the County Resources web page at \url{http://innerweb/ohp/countyRes/CountyEligTA.shtml}, when determining eligibility in ABD cases involving deeming of income.

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MEMTL 83 (Medicaid: Third-Party Insurance Company Cooperation)

Medicaid Eligibility Manual Transmittal Letter No. 83

September 12, 2012

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Third-Party Insurance Company Cooperation

This MEMTL contains two rules from Chapter 5101:1-38 of the Administrative Code, adopted under section 111.15 of the Revised Code.

The effective date of the amended rules is September 9, 2012.

**Chapter 2 Application Processing**

**5101:1-38-01 Medicaid: Individual and Administrative Agency Responsibilities**

This rule is amended to clarify cooperating with third-party insurance companies is a responsibility of the individual applying for Medicaid and to remove language on attending the face-to-face interview.

**5101:1-38-01.8 Medicaid: Conditions of Eligibility for Each Applicant or Recipient**

This rule is amended to clarify that the individual is responsible for cooperating with third-party insurance companies, Medicaid providers, managed care plans, and managed care plan’s contracted providers with request for information or to return payments received as a condition of eligibility.

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MEMTL 82 (Medicaid: Presumptive Eligibility for Children Younger Than Age Nineteen)

Medicaid Eligibility Manual Transmittal Letter No. 82
June 29, 2012

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Presumptive Eligibility for Children Younger Than Age Nineteen

Section 5111.0125 of Amended Substitute House Bill 153 of the 129th General Assembly mandates the inclusion of additional entities as being permitted to perform presumptive eligibility determinations for children.

Chapter 2 Application Processing

Medicaid: 5101:1-38-40 Presumptive Eligibility for Children Younger Than Age Nineteen

This rule is amended to add hospitals, federally-qualified health centers (FQHCs) and FQHC look-alikes as entities permitted to make presumptive eligibility determinations for children. All other changes to the rule are for clarity and consistency with other rules.

This amended rule replaces the emergency-filed version of the same rule that was effective April 1, 2012, and makes permanent the changes introduced in the emergency rule.

The effective date of this amendment is July 1, 2012.

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MEMTL 81 (Medicaid: Presumptive Eligibility for Children Younger Than Age Nineteen)

Medicaid Eligibility Manual Transmittal Letter No. 81
March 28, 2012

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Presumptive Eligibility for Children Younger Than Age Nineteen

Section 5111.0125 of Amended Substitute House Bill 153 of the 129th General Assembly mandates the inclusion of additional entities as being permitted to perform presumptive eligibility determinations for children. This emergency rule is effective April 1, 2012. It replaces the prior version of the same rule that was effective July 1, 2010.

Chapter 2 Application Processing

5101:1-38-40 Presumptive Eligibility for Children Younger Than Age Nineteen

This rule is being amended to add hospitals, federally-qualified health centers (FQHCs) and FQHC look-alikes as entities permitted to make presumptive eligibility determinations for children. All other changes to the rule are for clarity and consistency with other rules.

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MEMTL 80 (Medicaid: Presumptive Eligibility for Pregnant Women)

Medicaid Eligibility Manual Transmittal Letter No. 80

March 28, 2012

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Presumptive Eligibility for Pregnant Women

Section 5111.0124 of Amended Substitute House Bill 153 of the 129th General Assembly establishes a program of presumptive Medicaid eligibility for pregnant women. Eligibility under this category is time-limited, and is limited in scope to outpatient prenatal care; this category does not cover labor and delivery or any other inpatient hospitalization.

Chapter 2 Application Processing

Medicaid: 5101:1-38-50 Presumptive Eligibility for Pregnant Women

This new rule replaces rule 5101:1-40-60. It describes the application processing requirements and eligibility criteria for pregnant women who are being presumptively determined to be eligible for Medicaid based on their pregnancy, Ohio residency, income, and U.S. citizenship status.

Notable changes from past practice include: self-declaration of pregnancy is sufficient verification for purposes of presumptive determinations; and, presumptive eligibility determinations will be able to be made by health care providers as well as by the CDJFS.

The effective date of this rule is April 1, 2012.

Chapter 4 Covered Families and Children (CFC)

Medicaid: 5101:1-40-60 Expedited Medicaid Eligibility Determinations

This rule is rescinded.

The effective date of this rescission is April 1, 2012.

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MEMTL 79 (Medicaid: Covered Group Eligibility for Family Planning Services)

Medicaid Eligibility Manual Transmittal Letter No. 79
January 5, 2012

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Covered Group Eligibility for Family Planning Services

The Patient Protection and Affordable Care Act of 2009 provided states the option to create a new Medicaid eligibility group to provide medical assistance for family planning services and supplies to individuals who meet the eligibility requirements of this new covered group.

This MEMTL contains one new rule from Chapter 5101:1-41 of the Administrative Code, adopted under section 111.15 of the Revised Code.

The effective date of the new rule is January 8, 2012.

**Chapter 5 Special Programs and Services**

5101:1-41-40 Medicaid: covered group eligibility for family planning services

This new rule outlines the eligibility criteria for individuals seeking family planning services. A description of the family planning services for this covered group can be found in rules 5101:3-21-02 and 5101:3-21-02.3 of the Administrative Code.

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MEMTL 78 (Medicaid: Income, Exemptions, and Disregards; Medicaid: Low-Income Families, Children, and Pregnant Women Budgeting)

Medicaid Eligibility Manual Transmittal Letter No. 78
January 5, 2012

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Income, Exemptions, and Disregards; Medicaid: Low-income Families, Children, and Pregnant Women Budgeting

This MEMTL contains one rule from Chapter 5101:1-37, two rules from Chapter 5101:1-38, and three rules from Chapter 5101:1-40 of the Administrative Code, adopted under section 111.15 of the Revised Code. These rules replace fourteen rescinded rules from these same Chapters. The rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the new rules is January 9, 2012.

Chapter 1
5101:1-37-01 Medicaid: Definitions
This rule is amended to make reference to the combined Medicaid income rule 5101:1-38-01.9 for definitions relating to Medicaid income and to add "legal custodians" to the definition of family.

Chapter 2
5101:1-38-01.2 Medicaid: Application, Determination, and Redetermination Processes
This rule is amended to remove language on the face-to-face requirement for Aged, Blind, and Disabled (ABD) Medicaid.

5101:1-38-01.9 Medicaid: Income, Exemptions, and Disregards.
This is a new rule that applies to all Medicaid covered groups income, exemption, and disregard requirements as well as definitions relating to income and income conversion. This rule contains language from the following existing Medicaid rules:
5101:1-39-08 Medicaid: Income
5101:1-39-15.3 Medicaid: Treatment of Income Received from Participation in Programs Established Under the National and Community Services Trust Act of 1993
5101:1-39-16 Medicaid: Treatment of Unearned income
5101:1-40-08.1 Medicaid: Income Computations for Determining Eligibility Under the Medicaid Healthy Start Covered Group
5101:1-40-20 Covered Families and Children (CFC) Medicaid: Income
5101:1-40-20.3 Covered Families and Children (CFC) Medicaid: Unearned Income
5101:1-40-20.4 ADC-Related Medicaid: Earned Income
Chapter 3

This rule is rescinded and reorganized into Ohio Administrative Code (OAC) rules 5101:1-38-01 Medicaid: Individual and Administrative Agency Responsibilities, 5101:1-38-01.8 "Medicaid: Conditions of Eligibility for Each Applicant or Recipient", and the new OAC rule 5101:1-38-01.9 "Medicaid: Income, exemptions, and disregards."

5101:1-39-15.3 Medicaid: Treatment of Income Received from Participation in Programs Established Under the National Community Services Trust Act of 1993
This rule is rescinded and the language is found in new OAC rule 5101:1-38-01.9 "Medicaid: Income, Exemptions, and Disregards."


This rule is rescinded and reorganized into OAC rule 5101:1-38-01 "Medicaid: Individual and Administrative Agency Responsibilities", and new OAC rule 5101:1-38-01.9 "Medicaid: Income, Exemptions, and Disregards."

This rule is rescinded and the language is found in new OAC rule 5101:1-38-01.9 "Medicaid: Income, Exemptions, and Disregards."

Chapter 4

5101:1-40-02.1 Medicaid: coverage for families
This rule is amended to add language on low-income families eligibility when an individual is eligible for Ohio Works First (OWF) cash assistance.

5101:1-40-02.2 Medicaid: coverage for children
This rule is amended to add language on the use of parental income when determining Medicaid eligibility for children.

5101:1-40-08.1 Medicaid: Income Computations for Determining Eligibility Under the Medicaid Healthy Start Covered Group
This rule is rescinded and reorganized into rule 5101:1-40-02.2 "Medicaid: Coverage for Children" and new rule 5101:1-40-20 "Medicaid: Low-income Families, Children, and Pregnant Women Budgeting."

5101:1-40-20 Covered Families and Children Medicaid: Income
This rule is rescinded and made new, with the new title "Medicaid: Low-income Families, Children, and Pregnant Women Budgeting", as part of a project to reorganize and clarify Medicaid income rules. Language from the rescinded rule 5101:1-40-20 of the Administrative Code is in OAC rule 5101:1-38-01.8 "Medicaid: Conditions of Eligibility for Each Applicant or Recipient" and in new OAC rule 5101:1-38-01.9 "Medicaid: Income, Exemptions, and Disregards."

5101:1-40-20.1 Covered Families and Children (CFC) Medicaid: Exempt Income
This rule is rescinded and reorganized into new OAC rules 5101:1-38-01.9 "Medicaid: Income, Exemptions, and Disregards" and 5101:1-40-20 "Medicaid: Low-income Families, Children, and Pregnant Women Budgeting."

5101:1-40-202 ADC-Related Medicaid: Non-Exempt Income
This rule is rescinded and the language is found in new OAC rule 5101:1-38-01.9 "Medicaid: Income, Exemptions, and Disregards."

5101:1-40-20.3 Covered Families and Children (CFC) Medicaid: Unearned Income

5101:1-40-20.4 ADC-Related Medicaid: Earned Income
This rule is rescinded and the language is found in new OAC rule 5101:1-38-01.9 "Medicaid: Income, Exemptions, and Disregards."

5101:1-40-20.5 Covered Families and Children Medicaid: Disregards of Earned Income
This rule is rescinded and the language is found in new OAC rule 5101:1-40-20 "Medicaid: Low-income Families, Children, and Pregnant Women Budgeting."

5101:1-40-22 Covered Families and Children (CFC) Medicaid: Allocating Income to Members of an Assistance Group
This rule is rescinded and the language is found in new OAC rule 5101:1-40-20 "Medicaid: Low-income Families, Children, and Pregnant Women Budgeting."

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MEMTL 77 (Medicaid: Rescission of Children's Buy-In Program)

Medicaid Eligibility Manual Transmittal Letter No. 77

December 30, 2011

To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Rescission of Children's Buy-In Program

Section 309.33.60 of Am. Sub. House Bill 153 of the 129th General Assembly repealed the CBI program, effective January 1, 2012.

The effective date of this rule rescission is January 1, 2012.

Chapter 5: Special Programs and Services

Medicaid: 5101:1-42-30 Children's Buy-In Program: Eligibility

This rule is rescinded.

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MEMTL 76 (RSS Program)

Medicaid Eligibility Manual Transmittal Letter No. 76

October 4, 2011

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Residential State Supplement (RSS) Program

The RSS rules in the Ohio Administrative Code were recently amended via emergency filing to reflect a change in administration of the RSS program from the Ohio Department of Aging (ODA) to the Ohio Department of Mental Health (ODMH), as required by the enactment of Am. Sub. H.B. 153 of the 129th General Assembly.

The RSS rules are now shortened and reorganized for clarity with this permanent rule package. No changes were made at this time to the eligibility criteria for RSS.

The effective date of the new rules and the rescission of the old rules is September 29th, 2011.

Chapter 5 Special Programs and Services

5101:1-17-01 The residential state supplement (RSS) program

This rule is rescinded and made new. It incorporates parts of rescinded rules 5101:1-17-01, 5101:1-17-03, and 5101:1-17-04.

5101:1-17-02 RSS eligibility requirements

This rule is rescinded and made new. It incorporates parts of rescinded rules 5101:1-17-02 and 5101:1-17-04. This rule now includes both non-financial and financial eligibility criteria.

5101:1-17-03 RSS registration and enrollment process

This rule is rescinded and made new, with a new title, "Determination of RSS Payment." The contents of the rescinded rule are incorporated into new rule 5101:1-17-01. This new rule comprises the contents of rescinded rule 5101:1-17-05, shortened and reorganized.

5101:1-17-04 Medicaid and RSS financial eligibility determinations

This rule is rescinded. The contents are incorporated into new rule 5101:1-17-02.

5101:1-17-05 Determination of RSS payment

This rule is rescinded. The contents are incorporated into new rule 5101:1-17-03.

5101:1-17-06 RSS financial need standards and allowable fees

This rule is rescinded. This information is updated when required by legislation, via a Medicaid Eligibility Procedure Letter (MEPL). The current figures are also available in CRIS-E table TOSS.

5101:1-17-07 Pass-along of SSI income cost-of-living adjustments (COLA) for RSS

This rule is rescinded. This information is updated with the annual COLA update MEPL.

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MEMTL 75 (Medicaid: SSI Refugee Extension Rescission)

Medicaid Eligibility Manual Transmittal Letter No. 75

October 4, 2011

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: SSI Refugee Extension Rescission

H.R. 2608, which was signed into law as Public Law 110-328 on September 30, 2008, had authorized a two-year extension of the seven-year limit on potential Medicaid eligibility for elderly and disabled refugees, but only effective during the period 10/1/08 through 09/30/2011.

Elderly and disabled refugees can still avail themselves of the seven years of Medicaid coverage that is currently permitted under rule 5101:1-38-02.3 of the Administrative Code.

Chapter 2

Medicaid: 5101:1-38-02.6 Medicaid: Medicaid Extension for Elderly and Disabled Refugees

This rule is rescinded effective October 6, 2011.

Fiscal Impact

The rescission of this rule does not impose any new requirements on county agencies, and should result in no fiscal impact on the county agencies.

Training Statement

The rescission of this rule will require training or technical assistance to be provided to county staff by ODJFS. Clarification regarding this rule will be available to county staff through the Medicaid Eligibility Technical Assistance staff, who can be reached via email at: MEDICAID_ELIGIBILITY_TA@jfs.ohio.gov.

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MEMTL 74 (Medicaid: Revisions to Forms JFS 07102 {Rev. 08/2011} and JFS 07102-I {Rev. 08/2011} for MITS Implementation)

Medicaid Eligibility Manual Transmittal Letter No. 74

September 2, 2011

To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Revisions to Forms JFS 07102 (Rev. 08/2011) and JFS 07102-I (Rev. 08/2011) for MITS Implementation

This Medicaid Eligibility Manual Transmittal Letter revises form JFS 07102, "Changes in Medicaid Health Care Coverage Date and Medicare Buy-In Eligibility" and form JFS 07102-I, "Instructions for completing Changes in Medicaid Health Care Coverage Date and Medicare Buy-In Eligibility". These revisions are necessary for the Ohio Department of Job and Family Services (ODJFS) to process the County Department of Job and Family Services' requests to manually update eligibility information in the Medicaid Technology System (MITS).

The effective date for the forms is August 2, 2011.

Forms

**JFS 07102**, "Changes in Medicaid Health Care Coverage Date and Medicare Buy-In eligibility" (Rev. 08/2011)

The revised form JFS 07102 requires additional eligibility information from the CDJFS to include:

Section I

- Requesting the Med Class from CRISE IQEL.
- Requesting additional information regarding Medicare premium assistance programs and other health insurance available to the consumer.

Section II

- Adding a new section for the CDJFS to request Medicare coverage updates.

**JFS 07102-I**, "Instructions for completing Changes in Medicaid Health Care Coverage Date and Medicare Buy-In Eligibility" (Rev. 08/2011)

The JFS 07102-I is revised to update the instructions for completing the JFS 07102 in Sections I and II.

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MEMTL 73 (Medicaid: Coverage for an Individual at Least Age Nineteen and Younger than Age Twenty-One)

Medicaid Eligibility Manual Transmittal Letter No. 73

October 4, 2011

To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Coverage for an Individual at Least Age Nineteen and Younger than Age Twenty-One

This MEMTL contains one new rule from Chapter 5101:1-40 of the Administrative Code, adopted under section 111.15 of the Revised Code. This rule replaces five rescinded rules from the same Chapter. The rule was reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the new rule and the recissions of the old rules is October 3, 2011.

Chapter 4 Covered Families and Children (CFC)

5101:1-40-02.4 Medicaid: Coverage for an individual at least age nineteen and younger than age twenty-one

This is a new rule that outlines the eligibility criteria for an individual at least age nineteen and younger than twenty-one and removes the resource limit for this covered group.

5101:1-40-14 Covered families and children (CFC) Medicaid: Resources: Application, Definitions, Availability, and Limitations

This rule is rescinded and the contents of this rule can be found in Chapter 5101:1-39 of the Administrative Code.

5101:1-40-15 ADC-Related Medicaid: Resources: Liquid Assets

This rule is rescinded and the contents of this rule can be found in Chapter 5101:1-39 of the Administrative Code.

5101:1-40-16 ADC-Related Medicaid: Exempt/Nonexempt Resources - Exchange and Transfer - Emergency Loss/Replacement of Exempt Resources

This rule is rescinded and the contents of this rule can be found in Chapter 5101:1-39 of the Administrative Code.

5101:1-40-17 ADC-Related Medicaid: Resources: Trusts

This rule is rescinded and the contents of this rule can be found in Chapter 5101:1-39 of the Administrative Code.

5101:1-40-25.1 Medicaid: Budgeting Methodology for individuals Under the Age of Twenty-One Not Living With a Parent or Spouse

This rule is rescinded and some of its contents incorporated in new rule 5101:1-40-02.4 of the Administrative Code.

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MEMTL 72 (Healthchek Poster JFS 08137 {English, Spanish and Somali versions})

Medicaid Eligibility Manual Transmittal Letter No. 72
August 2, 2011

To: All County Departments of Job and Family Services (CDJFS) locations, and other entities who distribute or accept applications for medical assistance.

From: Michael B. Colbert, Director

Subject: Healthchek Poster JFS 08137 (English, Spanish and Somali versions)

Attached are updated English, Spanish (SPA) and Somali (SOM) versions of the Healthchek JFS 08137 poster.

In compliance with Ohio Revised Code 5111.016, each Ohio County Department of Job and Family Services (CDJFS) or other entity that distributes or accepts applications for medical assistance must display Healthchek information in a prominent area.

These posters are intended for display in the agency's waiting rooms and / or hallways. Please adhere a label with the CDJFS' Healthchek Coordinator's phone number on the designated line on the bottom left corner of the poster. Specific counties will receive the Spanish and Somali versions as requested.

Healthchek Poster JFS 08137

The Healthchek Poster JFS 08137 has been updated from the 10/2006 version. Please replace all 10/2006 or earlier posters with the attached 6/2011 poster.

Training has already been provided and will continue to be provided regarding Healthchek services. The changes to this poster bring it in line with current training per the revised Healthchek rule 5101:1-38-05.

Fiscal Impact

The revisions to the poster do not impose any new requirements on county agencies and the implementation of these changes should result in no fiscal impact on the county agencies.

Training Statement

The revisions to the poster will not require additional training or technical assistance to be provided to county staff by ODJFS. Clarification regarding these revisions will be available to county staff through the Children's Health Section staff, who can be reached via email at Healthchek_PRS@odjfs.state.oh.us.
Am. Sub. H.B. 153 of the 129th General Assembly transfers administration of the RSS program from the Ohio Department of Aging (ODA) to the Ohio Department of Mental Health (ODMH), effective July 1, 2011.

The RSS Ohio Administrative Code rules are being amended to reflect the change from ODA to ODMH. No other changes are being made to the RSS program at this time. These amended rules are adopted under the emergency provisions of division (B)(2) of section 111.15 of the Ohio Revised Code, and are effective July 1, 2011.

**Chapter 5**

**Medicaid: 5101:1-17-01 The Residential State Supplement Program**

All references to ODA are replaced with references to ODMH, and Ohio Revised Code (ORC) citations are updated to reflect the transfer of the RSS program to ODMH.

**Medicaid: 5101:1-17-02 RSS Eligibility Requirements**

All references to ODA are replaced with references to ODMH, all references to the PASSPORT administrative agency (PAA) are replaced with references to the residential state supplement administrative agency, and ORC citations are updated to reflect the transfer of the RSS program to ODMH.

**Medicaid: 5101:1-17-03 RSS Registration and Enrollment Process**

All references to ODA are replaced with references to ODMH, and ORC citations are updated to reflect the transfer of the RSS program to ODMH.

**Medicaid: 5101:1-17-05 Determination of RSS Payment**

All references to ODA are replaced with references to ODMH, and ORC citations are updated to reflect the transfer of the RSS program to ODMH.

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MEMTL 70 (Medicaid: Definitions, Responsibilities, Application Processing, Conditions of Eligibility, U.S. Citizenship Documentation, and Covered Groups)

Medicaid Eligibility Manual Transmittal Letter No. 70

July 15, 2011

To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Definitions, Responsibilities, Application Processing, Conditions of Eligibility, U.S. Citizenship Documentation, and Covered Groups

This MEMTL contains one rule from Chapter 5101:1-37, four rules from Chapter 5101:1-38, and 3 rules from Chapter 5101:1-40 of the Administrative Code, adopted under section 111.15 of the Revised Code. These rules replace eight rescinded rules from these same Chapters. The rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rules is July 17, 2011.

Chapter 1 Introduction to Medicaid General Policy

5101:1-37-01 Medicaid: definitions

This rule is amended to add the definitions of "allocation" to include in the definition "deeming" and "electronic equivalent" and expand on the definition of "countable income" to include in the definition "net countable family income" and "net income".

Chapter 2 Application Processing

5101:1-38-01 Medicaid: individual and administrative agency responsibilities

This rule is amended to add references to rules 5101:1-38-01.2 and 5101:1-38-01.8 of the Administrative Code.

5101:1-38-01.2 Medicaid: application, determination, and redetermination processes

This rule is amended to add a reference to "electronic equivalent".

5101:1-38-01.8 Medicaid: conditions of eligibility for each applicant or recipient

This rule is amended to add clarification to an individual being a U.S. citizen and to remove references to "reasonable opportunity".

5101:1-38-02 Medicaid: United States (U.S.) citizenship documentation

This rule is amended to add clarification on individuals' statement of U.S. citizenship and the administrative agency’s use of the social security administration's electronic data exchange system to verify U.S. citizenship. Also, federal guidance now requires a person born in Puerto Rico who uses a U.S. passport to verify U.S. citizenship, to have a current, valid U.S. passport.

Chapter 4 Covered Families and Children (CFC)

5101:1-40-01 Covered families and children (CFC) medicaid: assistance groups and definitions

This rule is rescinded and some of its contents are incorporated into rules 5101:1-37-01, 5101:1-40-02.1, 5101:1-40-02.2, and 5101:1-40-02.3 of the Administrative Code.

5101:1-40-01.1 Covered families and children (CFC) medicaid: covered groups

This rule is rescinded and some of its contents are incorporated into rules 5101:1-40-02.1 and 5101:1-40-02.2 of the Administrative Code.

5101:1-40-02 Medicaid: coverage for an individual in receipt of Ohio works first (OWF)

This rule is rescinded and some of its contents are incorporated into rule 5101:1-40-02.1 of the Administrative Code.
**5101:1-40-02.1 Medicaid: coverage for families**

This rule is rescinded and replaced with a new title to clarify Medicaid eligibility criteria for low-income families. This rule now incorporates information from rescinded rules 5101:1-40-01.1, 5101:1-40-02, 5101:1-40-05.1, and 5101:1-40-07 of the Administrative Code.

**5101:1-40-02.2 Medicaid: coverage for children**

This rule is rescinded and replaced with a new title to clarify the requirements of covered groups for children under age nineteen. The language in this rule has been simplified where possible, and reorganized for clarity. This rule includes information from rescinded rules 5101:1-40-01, 5101:1-40-01.1, and 5101:1-40-08 of the Administrative Code.

Additionally, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions designed to ensure immediate coverage for newborn children born to women covered by Medicaid. Newborns are no longer required to live with the birth mother to remain covered under Medicaid. CHIPRA also amended the citizenship documentation requirements under the Deficit Reduction Act of 2005. A deemed newborn born to a Medicaid eligible woman is considered as automatically having provided documentation of citizenship and identity when eligibility is renewed on the child’s first birthday; no further documentation of citizenship is required.

*Note:* Newborns born to individuals in the following situations are also deemed eligible for Medicaid:

- Women residing in a public institution who are in a "suspended for payment but eligible for Medicaid" status.
- Children in youth services who are in a "suspended for payment but eligible for Medicaid" status.
- Children eligible for Medicaid who are in the custody of a public children services agency (PCSA) or private child placing agency (PCPA), in receipt of adoption or foster care assistance under Title IV-E, or in receipt of state or federal adoption assistance.

**5101:1-40-02.3 Medicaid: coverage for pregnant women**

This new rule contains information from rule 5101:1-40-08 of the Administrative Code, which is rescinded. This rule addresses eligibility for the covered group composed of pregnant women.

**5101:1-40-05.1 Medicaid: four-month extended coverage**

This rule is rescinded and some of its contents are incorporated into rule 5101:1-40-02.1 of the Administrative Code.

**5101:1-40-07 Covered families and children medicaid: medicaid eligibility and OWF sanctions**

This rule is rescinded and some of its contents are incorporated into rule 5101:1-40-02.1 of the Administrative Code.

**5101:1-40-08 Medicaid: coverage for children and pregnant women**

This rule is rescinded. Information regarding the covered group composed of children under the age of 19 is incorporated into new rule 5101:1-40-02.2 of the Administrative Code, and information regarding the covered group composed of pregnant women is incorporated into new rule 5101:1-40-02.3 of the Administrative Code.

**5101:1-40-25 Covered families and children medicaid: low income families (LIF)**

This rule is rescinded and some of its contents are incorporated into rule 5101:1-40-02.1 of the Administrative Code.

**5101:1-40-26 Medicaid: standards of need**

This rule is rescinded and some of its contents are incorporated into rules 5101:1-37-01, 5101:1-40-02.1, 5101:1-40.02.2, and 5101:1-40-02.3 of the Administrative Code.

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MEMTL 69 (Medicaid: Healthchek Processing and Related Form)

Medicaid Eligibility Manual Transmittal Letter No. 69
February 16, 2011

To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Healthchek Processing and Related Form

The rule addressed in this transmittal letter was rescinded and made new to incorporate process changes required for the operation of the Healthchek program. The rule was reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rule is February 14, 2011.

Chapter 5

Medicaid: 5101:1-38-05, "County JFS responsibilities regarding Healthchek (early periodic screening, diagnostic and treatment services)," was rescinded and made new to provide a detailed process of County Department of Job and Family Services (CDJFS) Healthchek administrative and support service requirements.

The following significant changes are included in the replacement rule:

Definitions are aligned for Medicaid eligibility, Medicaid services, and Child Support. The Local Program Management Description is changed to the Healthchek Services Implementation Plan. A guidance letter further explaining this change will be provided at a later date. The CDJFS is now required to enter data into the electronic eligibility system for Healthchek; this includes completing form JFS 03528 "HEALTHCHEK and Pregnancy Related Services Information Sheet" (rev. 2/2011).

Additionally, as part of the informing process, the CDJFS will be required to inform a consumer of how to access 1) prior authorization, and 2) transportation assistance. Healthchek Coordinators are required to attend trainings provided by ODJFS. Finally, consumer responsibilities are also outlined in this rule.

FORM:

Form JFS 03528 "HEALTHCHEK and Pregnancy Services Assessment" is obsolete and replaced with new Form JFS 03528 "Healthchek and Pregnancy Related Services Information" (rev. 2/2011). The JFS 03528 is formatted in a manner that will help the individual fill out the form and interact with the individual's Healthchek Coordinator. The form also includes a cover letter providing more detailed information about the services available through Healthchek. Once completed, this form is shared with the individual's managed care plan (MCP), if applicable. Please note: The instructions for this form will be forthcoming in a future guidance letter, as well as having the form translated to Spanish.

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MEMTL 68 (Medicaid: Continuous Eligibility for Children)

Medicaid Eligibility Manual Transmittal Letter No. 68
September 30, 2010

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Continuous Eligibility for Children

The Children's Health Insurance Program Reauthorization Act of 2009 encourages states to implement changes intended to accelerate the enrollment of Medicaid-eligible children and retain those children once enrolled.

One of these changes, Continuous Eligibility for Children, was implemented by the Ohio Department of Job and Family Services on an emergency basis on April 1, 2010, with permanent rules taking effect on July 1, 2010. Due to a change in federal guidance, this rule is being revised.

The effective date of the rule is October 15, 2010.

Chapter 2


This amended rule describes the twelve-month period of continuous coverage for a Medicaid-eligible child younger than age nineteen, and the conditions under which the child's coverage ends during the continuous coverage period.

Under revised rule 5101:1-38-30, children eligible for Medicaid only with a spenddown are again included in continuous coverage. As in the emergency rule, any child found eligible for Medicaid remains eligible for one year regardless of changes in family income, household size, household composition, or any other circumstances unless the child: is no longer an Ohio resident, dies, reaches age 19, or fails to pay a premium (if the child receives Medicaid under any category of assistance that requires payment of a premium). This includes any child whose eligibility was terminated since July 1, 2010.

A child is not eligible for continuous coverage if the child's coverage is:

- Presumptive coverage under rule 5101:1-38-40 of the Ohio Administrative Code (OAC); or
- Alien emergency medical assistance under rule 5101:1-41-20 of the OAC; or
- Children's buy-in under rule 5101:1-42-30 of the OAC; or
- Refugee medical assistance under rule 5101:1-42-90 of the OAC.

During a child's year of continuous eligibility, a child's spenddown, patient liability, or premium obligation will not increase as the result of any income or other changes.

Forms

JFS 03332 "Notice of Denial of Medicaid Presumptive Coverage" (Rev. 10/2010)

Form JFS 03332 explains presumptive coverage, sets out the requirements for a child to receive presumptive coverage, and provides spaces for a county worker to indicate which eligibility criteria a child did not meet. This form has been revised to include the receipt of presumptive coverage within the last 12 months as a reason for denial of presumptive coverage.

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MEMTL 67 (Amendment to Rule 5101:1-38-02.3, Medicaid: Qualified Aliens)

Medicaid Eligibility Manual Transmittal Letter No. 67
September 8, 2010

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Amendment to Rule 5101:1-38-02.3, Medicaid: Qualified Aliens

This MEMTL contains one rule from Chapter 5101:1-38 of the Administrative Code. Rule 5101:1-38-02.3 (effective 10/8/09) is amended effective October 1, 2010.

The Department of Defense Appropriations Act of 2010, H.R. 3326, was signed into law on December 19, 2009, and contains provisions requiring that Afghan and Iraqi Special Immigrant Visa (SIV) holders be treated the same as refugees for Medicaid purposes.

Chapter 2
Medicaid: 5101:1-38-02.3 Medicaid: Qualified Aliens

Rule 5101:1-38-02.3 of the Administrative Code is amended to remove references to the previous eight-month time limit for such individuals, and to bring the rule into compliance with the new federal legislation.

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MEMTL 66 (JFS 07220 and JFS 07227)  
Medicaid Eligibility Manual Transmittal Letter No. 66  
August 2, 2010

To: All Medicaid Eligibility Manual Holders  
From: Douglas E. Lumpkin, Director  
Subject: Form JFS 07220 "Medicaid Eligibility Review Checklist" and Form JFS 07227 "Healthy Start/Healthy Families Follow-up Letter"

In an effort to reduce printing costs and streamline processes for the county department of job and family services (CDJFS), ODJFS made changes to the following forms.

**Forms**

**JFS 07220 'Medicaid Eligibility Review Verification Request Checklist' (rev. 2/2010)**

This form is restructured to meet the needs of all Medicaid programs and to support Medicaid rules. The form is intended for use by the CDJFS at initial application and reapplication to provide consumers with a notice of verifications needed for eligibility determination. If the consumer has not provided the required verifications by the 10th day, a second notice shall be sent by the CDJFS. A 'Second Notice' box is added for workers to use when sending out a second request for verifications. Also, a box is added at the bottom for consumers to report any change of address or contact information. The **JFS 07220-S** Spanish equivalent will be translated at a later date.

**JFS 07227 'Healthy Start/Healthy Families Follow-up Letter’**

This form is obsolete and will no longer be used.

**JFS 07227S 'Healthy Start/Healthy Families Follow-up Letter’**

This form is obsolete and will no longer be used.

Form JFS 07220 is available from ODJFS Forms Central.

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MEMTL 65A (Medicaid: Continuous and Presumptive Eligibility for Children)

Medicaid Eligibility Manual Transmittal Letter No. 65A
June 21, 2010

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Continuous and Presumptive Eligibility for Children

The Children's Health Insurance Program Reauthorization Act of 2009 encourages states to implement changes intended to accelerate the enrollment of Medicaid-eligible children and retain those children once enrolled.

Two of these changes, Continuous Eligibility for Children and Presumptive Eligibility for Children, are being implemented by the Ohio Department of Job and Family Services. Due to federal timelines, these changes were first implemented April 1, 2010, by emergency filing. These emergency rules are now replaced by permanent rules.

The effective date of these rules is July 1, 2010.

Chapter 2


This new rule describes the twelve-month period of continuous coverage for a Medicaid-eligible child younger than age nineteen, and the conditions under which the child's coverage ends during the continuous coverage period.

Most children, once found eligible for Medicaid, will remain Medicaid-eligible for one year regardless of changes in family income, household size, household composition, or any other circumstances unless the child: is no longer an Ohio resident, dies, reaches age 19, or fails to pay a premium (if the child receives Medicaid under any category of assistance that requires payment of a premium).

During a child's year of continuous eligibility, a child's patient liability or premium obligation will not increase as the result of any income or other changes.

A child is not eligible for continuous coverage if the child's coverage is:

- Presumptive coverage under rule 5101:1-38-40 of the Ohio Administrative Code (OAC); or
- Coverage based on paying a spenddown under rule 5101:1-39-10 of the OAC; or
- Alien emergency medical assistance under rule 5101:1-41-20 of the OAC; or
- Children's buy-in under rule 5101:1-42-30 of the OAC; or
- Refugee medical assistance under rule 5101:1-42-90 of the OAC.

Note: The exclusion of spenddown children from continuous coverage is a change from the prior policy.


This new rule describes the conditions under which a child younger than nineteen may receive time-limited medical assistance as the result of an initial, simplified eligibility determination. No face-to-face interview is necessary for this simplified determination.

When an application for medical assistance is received on behalf of a child, the child is eligible for presumptive coverage if, based on the family's self-declared statements on a signed application, the child is: younger than nineteen, a resident of Ohio, a U.S. citizen or qualified alien, with gross family income no more than 200% of the Federal Poverty Level (FPL) for the family size. A chart showing 200% FPL for different family sizes is published annually in a Medicaid Eligibility Procedure Letter.

If a child is determined to be presumptively eligible, the child receives presumptive coverage beginning on the date of that determination. There is no retroactive presumptive coverage. The child's presumptive coverage
ends on the date when the CDJFS approves or denies the child’s Medicaid application under rule 5101:1-38-01.2 of the Administrative Code.

If a child is not presumptively eligible, the child or family shall be notified of the denial of presumptive coverage using form JFS 03332, "Notice of Denial of Medicaid Presumptive Coverage" (7/2010). This form must be given or sent (electronically, by fax, or mailed) to the child or family at the time of the presumptive determination. The use of this notice is a change from the prior policy.

This presumptive process does not replace the Medicaid application process set out in rule 5101:1-38-01.2 of the Administrative Code. A child who is ineligible for presumptive coverage may be eligible for Medicaid, while a child who is eligible for presumptive coverage may not be eligible for Medicaid.

**Forms**

**JFS 03332** "Notice of Denial of Medicaid Presumptive Coverage"

New form JFS 03332 explains presumptive coverage, sets out the requirements for a child to receive presumptive coverage, and provides spaces for a county worker to indicate which eligibility criteria a child did not meet. This form may be hand-delivered, mailed, emailed, or faxed to the child's family or representative.

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MEMTL 65 (Medicaid: Continuous and Presumptive Eligibility for Children)

Medicaid Eligibility Manual Transmittal Letter No. 65

March 31, 2010

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Continuous and Presumptive Eligibility for Children

The Children's Health Insurance Program Reauthorization Act of 2009 encourages states to implement changes intended to accelerate the enrollment of Medicaid-eligible children and retain those children once enrolled.

Two of these changes, Continuous Eligibility for Children and Presumptive Eligibility for Children, are being implemented by the Ohio Department of Job and Family Services. Due to federal timelines, these changes are being implemented April 1, 2010, by emergency filing. The emergency rules will later be replaced by permanent rules.

The effective date of both rules is April 1, 2010.

Chapter 2


This new rule describes the twelve-month period of continuous coverage for a Medicaid-eligible child younger than age nineteen, and the conditions under which the child's coverage ends during the continuous coverage period.

Any child who is found to be eligible for Medicaid will remain eligible for one year regardless of changes in family income, household size, household composition, or any other circumstances unless the child: is no longer an Ohio resident, dies, reaches age 19, or fails to pay a premium (if the child receives Medicaid under any category of assistance that requires payment of a premium).

During a child's year of continuous eligibility, a child's spenddown, patient liability, or premium obligation will not increase as the result of any income or other changes.


This new rule describes the conditions under which a child younger than nineteen may receive time-limited medical assistance as the result of an initial, simplified eligibility determination.

When an application for medical assistance is received on behalf of a child, the child is eligible for presumptive coverage if, based on the family's self-declared statements on a signed application, the child is: younger than nineteen, a resident of Ohio, a U.S. citizen or qualified alien, with gross family income no more than 200% of the Federal Poverty Level (FPL) for the family size. A chart showing 200% FPL for different family sizes is published annually in a Medicaid Eligibility Procedure Letter.

If a child is determined to be presumptively eligible, the child receives presumptive coverage beginning on the date of that determination. There is no retroactive presumptive coverage. The child's presumptive coverage ends on the date when the CDJFS approves or denies the child's Medicaid application under rule 5101:1-38-01.2 of the Administrative Code.

This presumptive process does not replace the Medicaid application process set out in rule 5101:1-38-01.2 of the Administrative Code. A child who is ineligible for presumptive coverage may be eligible for Medicaid, while a child who is eligible for presumptive coverage may not be eligible for Medicaid.

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MEMTL 64 (Medicaid: Rescission of Rule 5101:1-39-53.5 Direct Reimbursement for QMB or SLMB Medicaid)

Medicaid Eligibility Manual Transmittal Letter No. 64
April 7, 2010

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Rescission of Rule 5101:1-39-53.5 Direct Reimbursement for QMB or SLMB Medicaid

Rule 5101:1-39-53.5 of the Administrative Code is being rescinded because portions of the rule set forth a procedure that is no longer necessary, while other portions unnecessarily duplicate another Administrative Code rule. This rule was reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rescission of this rule is May 1, 2010.

Chapter 3

5101:1-39-53.5 Direct Reimbursement of Medicare Premiums and/or Coinsurance and Deductibles to Individuals Eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Medicaid


Historically, rule 5101:1-39-53.5 addressed a particular issue - advancing Medicare premium refunds to consumers whose applications for Medicare Premium Assistance Programs under rules 5101:1-38-03 or 5101:1-39-01.1 of the Administrative Code had been erroneously denied or whose approval for these programs had been erroneously delayed. These refunds were advanced by ODJFS because of the significant delay between the date when coverage was approved in the Medicare buy-in system and the date when the Social Security Administration actually refunded money to the consumer. This delay has now been reduced to the point where the Social Security Administration can refund the consumer’s money as quickly as ODJFS can advance the refund. Therefore, there is no longer any benefit to consumers from completing the required paperwork, getting an advance of the expected refund, and then repaying the advance. ODJFS will no longer advance these refunds.

This rule also addressed refunds of Medicare co-pays, deductibles, and coinsurance for Qualified Medicare Beneficiaries under rule 5101:1-39-01.1 of the Administrative Code. Direct reimbursement of those expenses is still available pursuant to Administrative Code rule 5101:3-1-60.2 "Direct reimbursement for out-of-pocket expense incurred for Medicaid covered services".

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MEMTL 63 (Medicaid: Consumer Fraud and Erroneous Payments)

Medicaid Eligibility Manual Transmittal Letter No. 63
January 5, 2010

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Consumer Fraud and Erroneous Payments

This MEMTL contains one rule from Chapter 5101:1-37 and one rule from Chapter 5101:1-38 of the Administrative Code, adopted under section 111.15 of the Revised Code. The rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rule is February 1, 2010.

Chapter 1

5101:1-37-02 Medicaid: denial of assistance to individuals convicted of medicaid fraud.

This rule is being rescinded and not replaced. Federal law does not support denial of Medicaid assistance for residence fraud.

Chapter 2


This rule is rescinded and made new with a new title to clarify the requirements for the identification and referral of consumer fraud and erroneous Medicaid payments made on behalf of individuals of a medical assistance program. The requirements of the rule have been simplified and minimized where possible.

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MEMTL 62 (Medicaid: JFS 01958 Form Update)

Medicaid Eligibility Manual Transmittal Letter No. 62

March 11, 2010

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: JFS 01958 Form Update

Form

**JFS 01958 "Referral for Medicaid Continuing Eligibility Review"**

This form has been modified to assist Public Children Services Agencies (PCSAs) with the review of the final independent living plan with children who are within 90 days of aging out of foster care (emancipation). A new requirement of this final review is the obligation of the PCSAs to complete the JFS 07216 "Combined Programs Application" for Medicaid and to forward the application along with a signed and dated JFS 07236 "Rights and Responsibilities" to the CDJFS to determine eligibility. The JFS 01958 has been updated between sections I and II with additional instructions for the PCSA worker to follow in these circumstances.

CDJFS agencies should expect to see more applications coming from the PCSA for children aging out of foster care. If the emancipated child is not otherwise eligible for Medicaid, the CDJFS worker assigned to determine eligibility for aged out foster children should continue processing the applications in accordance with chapter 5101:1-38 and rule 5101:1-40-03 of the Administrative Code, respectively.

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http://innerapp.odjfs.state.oh.us/forms/inner.asp

**Forms Central Internet:**

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MEMTL 61 (Medicaid Premium Assistance Programs [MPAPs])

Medicaid Eligibility Manual Transmittal Letter No. 61

December 16, 2009

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid Premium Assistance Programs (MPAPs)

This MEMTL contains one rule from Chapter 5101:1-38 of the Administrative Code and two rules from Chapter 5101:1-39 of the Administrative Code, replacing the three existing rules of the same numbers. The effective date of these rules is January 1, 2010.

Chapter 2

5101:1-38-03 Medicare Buy-In

This rule is being rescinded and replaced as a result of a five-year rule review, to improve the clarity and organization of the rule and to reduce redundancy. The rule sets out eligibility criteria for benefits under the Medicare part B buy-in agreement between the Social Security Administration (SSA) and the Ohio Department of Job & Family Services (ODJFS); the beginning date of payment of Part A or Part B benefits; the date and effect of termination of benefits; and the steps required to coordinate enrollment of an individual in Part A or Part B benefits.

Chapter 3

5101:1-39-01.1 Medicaid Premium Assistance Programs

This rule is being rescinded and replaced as a result of the Medicare Improvements for Patients and Providers Act of 2008, which raised the resource limit for the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individual (QI-1) groups. For calendar year 2010, the resource limits for MPAPs will be $6,600 for an individual, and $9,910 for a couple. Each year, the resource limit will be adjusted based on the consumer price index. The rule was also reorganized and rewritten for clarity.

Note: Paragraph (G)(1)(b) states that if a person is entitled to Medicare Part A or Part B, whether or not a premium would be charged for those benefits, Medicaid is prohibited from paying for that person's prescriptions. This is due to a prohibition against Medicaid paying for prescriptions when an individual is eligible for the Medicare Part D prescription drug benefit. Medicare Part D is not specifically mentioned in the paragraph, however, because a person who is eligible for Part A or Part B is eligible for Part D whether or not that person chooses to enroll in Medicare Part D, and this eligibility triggers the prohibition against Medicaid paying for the person's prescriptions.

5101:1-39-01.2 Medicaid: qualified disabled and working individuals (QDWI)

This rule is being rescinded and replaced as a result of a five-year rule review. The rule has been reorganized and rewritten for clarity. The name of the rule and the category of Medicaid have been corrected to reflect the actual federal language.

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MEMTL 60 (Medicaid Estate Recovery)

Medicaid Eligibility Manual Transmittal Letter No. 60
December 16, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid Estate Recovery


The effective date of this rule is January 1, 2010.

Chapter 2

5101:1-38-10 Medicaid Estate Recovery

This rule is amended due to Section 115 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which changed federal estate recovery provisions. Medicare cost-sharing benefits paid after January 1, 2010, are not subject to estate recovery if the consumer was not permanently institutionalized. This exception was added to paragraph (C)(2), which addresses estate recovery for individuals who are fifty-five years of age or older and who are not permanently institutionalized.

Forms

JFS 07400 "Ohio Medicaid Estate Recovery"

The Ohio Medicaid Estate Recovery fact sheet, form JFS 07400, has been revised to reflect the exclusion of cost-sharing benefits paid after January 1, 2010, from estate recovery if the individual was not permanently institutionalized.

The signature block has been removed because, while federal regulations require counties to notify consumers of Estate Recovery, there is no requirement that a signature be obtained. Compliance with this requirement can be met by documenting in the electronic eligibility system the date that this form was provided to the consumer.

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MEMTL 59 (Medicaid: Application and Form Simplification)

Medicaid Eligibility Manual Transmittal Letter No. 59
December 2, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Application and Form Simplification

In an effort to reduce printing costs, the attached applications and forms have been revised to reduce the number of pages in each application and to eliminate the use of graphics, color printing, etc. Additional pages and language have been added to applications to address requirements of the National Voter Registration Act.

Applications
The following applications have been simplified and reformatted so that they can be printed on a standard printer. Electronic versions of these applications are available at Forms Central and can be completed electronically and then printed.

- **JFS 07103** "Application for Help with Medicare Expenses".
- **JFS 07161** "Ohio Breast & Cervical Cancer Project (BCCP) Medicaid Application".
- **JFS 07216** "Combined Programs Application".

To improve compliance with the National Voter Registration Act, voter registration forms have been added to all three applications. On each application, consumers are asked whether they wish to register to vote, and advised that assistance with registering to vote is available.

The **JFS 07236** "Rights and Responsibilities" form has been removed from all three applications, and will need to be separately provided and signed.

The JFS 07216 now includes information about and a checkbox for referrals to the Help Me Grow (HMG) program. CDJFS' shall forward referrals to their local HMG agency.

Forms

**JFS 07110** "Retroactive Medicaid Worksheet"

This form is no longer required as an application for retroactive Medicaid, but is still a useful tool for gathering the needed information. It has been simplified to gather only information necessary to determine eligibility for retroactive coverage.

**JFS 06723** "Designation of Authorized Representative"

This new form will not be a required form; it is intended to be a tool that enables a consumer to designate an authorized representative and clearly indicate the rights and responsibilities of that representative. The JFS 06723 is designed to allow a consumer to designate someone to work with the county on the consumer's behalf; this form does not authorize the county to represent the consumer to another agency.

**SSA-1696** "Appointment of Representative"

This is a Social Security Administration (SSA) form which can be completed by a consumer and a CDJFS worker (or multiple CDJFS workers, but not the CDJFS as an organization) in order to allow CDJFS workers to gather medical records and present them to the SSA in order to support a consumer's SSA application. Note: completing this form does not mean that the SSA will provide the CDJFS with copies of medical records gathered by the SSA.

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MEMTL 58 (Medicaid: Transitional Medical Assistance)

Medicaid Eligibility Manual Transmittal Letter No. 58

December 22, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Transitional Medical Assistance

The American Recovery and Reinvestment Act of 2009 (ARRA) gave states the option to eliminate the quarterly reporting requirement for transitional medical assistance and extend initial eligibility to 12 months of continuous eligibility. Rule 5101:1-40-05 of the Administrative Code is being rescinded and made new in order to reflect the changes. This rule was reviewed in accordance with section 119.032 of the Revised Code. The effective date of the rule is January 1, 2010.

Chapter 4

5101:1-40-05 Medicaid: transitional medical assistance

This rule is rescinded and made new. Individuals who transition from OWF/LIF Medicaid to transitional medical assistance (TMA) shall receive 12 months of TMA, without consideration of income. Changes include simplifying language regarding Medicaid eligibility criteria, adding language regarding 12 months of initial continuous eligibility, and removing language regarding quarterly income reporting.

Please Note:
CRISE will not be updated by January 1, 2010 to support the changes to the transitional medical assistance program. A desk aid shall be available on the County Resources webpage.

A CRISE view flash bulletin shall be issued when the electronic eligibility system is updated to correctly determine the full 12 months of TMA eligibility.

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MEMTL 57 (Disability Medical Assistance Program - Rescission)

Medicaid Eligibility Manual Transmittal Letter No. 57

October 22, 2009

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Disability Medical Assistance Program - Rescission


Chapter 5

Medicaid: 5101:1-42-01 Disability Medical Assistance (DMA) Program

This rule is rescinded as a result of Amended Substitute House Bill 1 of the 128th General Assembly, which eliminates the DMA program. As of the effective date of the rescission, counties shall no longer accept DMA applications, shall deny pending reapplications for DMA, and shall terminate any active DMA cases.

Although no formal pre-termination review is required for this program, county staff are encouraged to explore other categories of Medicaid for former DMA recipients, and to begin disability determinations as appropriate.

Effective date: November 1, 2009

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MEMTL 56 (Medicaid: RSS and Data Systems Rules)

Medicaid Eligibility Manual Transmittal Letter No. 56

October 19, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: RSS and Data Systems Rules

This MEMTL contains one rescinded and made new rule 5101:1-37-04 and one rescinded rule 5101:1-38-01.4 of the Administrative Code, adopted under section 111.15 of the Revised Code. The rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rules are November 1, 2009.

Chapter 2

Medicaid: 5101:1-38-01.4 Data systems and Medicaid health care coverage.

This rule is rescinded and is being incorporated into rules 5101:1-38-01.2 and 5101:1-39-04 of the Administrative Code. Paragraph 5101:1-39-04(C)(2) now states an individual must be a resident of the State of Ohio to be eligible for Medicaid. Rule 5101:1-38-01.2 now includes information regarding the use of the JFS 07102 and the correcting or backdating of Medicaid eligibility.

Chapter 3


This rule is rescinded and made new. This rule gives guidelines on how to process replacement checks for missing or damaged Medicaid checks.

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MEMTL 55 (Medicaid: Safeguarding, IVES and Certificate of Creditable Coverage and Privacy Notice)

Medicaid Eligibility Manual Transmittal Letter No. 55
October 16, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Safeguarding, Income Eligibility and Verification System (IVES) and Certificate of Creditable Coverage and Privacy Notice.

This MEMTL contains two rules from Chapter 5101:1-37 and one rule from Chapter 5101:1-38 of the Administrative Code, adopted under section 111.15 of the Revised Code. The rules replace the same three rescinded rules from these same Chapters. The rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of the rules is November 1, 2009.

Chapter 1


Existing OAC rule 5101:1-37-01.1 "Medicaid: Disclosure of Recipient Information and Confidentiality" is rescinded and replaced with this new rule, which describes the requirements of disclosing information, maintaining confidentiality and safeguarding information concerning individuals of a medical assistance program.

Some of the notable inclusions or changes in the rule include the following.

- Language referencing IEVS was removed and was included in rule 5101:1-37-03.1.
- Removed various language referencing HIPAA and moved it to rule 5101:1-38.01.5.

5101:1-37-03.1 Medicaid: income and eligibility verification system (IVES).

Existing OAC rule 5101:1-37-03.1 "Medicaid: Income and Eligibility Verification System" is rescinded and replaced with this new rule which describes the requirements to establish procedures for obtaining, using and verifying information relevant to determinations of eligibility.

Some of the notable inclusions or changes in the rule include the following.

- Removed language referencing CRIS-E now referred to as electronic eligibility system.
- Removed references to priority levels.
- Removed the specific sources and dates of IEVS matches.
- Removed reference to CRISE flash 61.

Chapter 2

5101:1-38-01.5 Medicaid: certificate of creditable coverage and privacy notice.

Existing OAC rule 5101:1-38-01.5 "Medicaid: Health Insurance Portability and Accountability Act (HIPAA)" is rescinded and replaced with this new rule and new title requiring administrative agencies to issue a certificate of creditable coverage and a privacy notice. Overall, the rule speaks to only two items; the certificate and the privacy notice.

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MEMTL 54 (Medicaid: Qualified Aliens)

Medicaid Eligibility Manual Transmittal Letter No. 54

September 30, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Qualified Aliens


Rule 5101:1-38-02.3 has been extensively rewritten for clarity, and also now incorporates information from the three rescinded rules listed in this MEMTL. Other information from the rescinded rules has been incorporated into a new desk aid entitled "Medicaid: U.S. Citizens and Non-Citizens."

Effective date: October 8, 2009.

Chapter 1


This rule is rescinded. Information regarding the use of the SAVE system is now incorporated into rule 5101:1-38-02.3 of the Administrative Code.

Chapter 2

Medicaid: 5101:1-38-02.3 Qualified Aliens.

This rule is rescinded and made new. Changes include simplifying and minimizing rule language, reorganizing the rule for clarity and incorporating information from rules 5101:1-37-03, 5101:1-38-02.4, and 5101:1-38-02.5 of the Administrative Code.


This rule is rescinded. Information regarding victims of trafficking is incorporated into rule 5101:1-38-02.3 of the Administrative Code.


This rule is rescinded. Information regarding indefinite detainees is incorporated into rule 5101:1-38-02.3 of the Administrative Code.

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MEMTL 53 (Medicaid: Conditions of Eligibility and Citizenship Documentation Rule)

Medicaid Eligibility Manual Transmittal Letter No. 53
September 30, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Conditions of Eligibility and Citizenship Documentation Rule.

This MEMTL contains two rules for Chapter 5101:1-38 of the Administrative Code. These two rules replace one rescinded rule from Chapter 5101:1-39 of the Administrative Code and three rescinded rules from Chapter 5101:1-38 of the Administrative Code. The rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date is October 15, 2009.

Chapter 1

5101:1-38-01.8 Medicaid: conditions of eligibility for each individual
This is a new rule that incorporates eligibility criteria currently found in Chapter 1 and Chapter 2 of the MEM. This rule sets forth conditions an individual applying for or receiving Medicaid must meet, regardless of covered group. In addition, to assist counties and consumers, this rule clarifies when self-declaration or documentation is required.

5101:1-39-54 Medicaid: Residency
This rule is rescinded. Portions of this rule are now found in new rule 5101:1-38-01.8 of the Administrative Code.

Chapter 2

5101:1-38-02 Medicaid: verification and reporting requirements
This rule is rescinded and made new. Verification and reporting requirements is found in new rule 5101:1-38-01.8 of the Administrative Code. The new version of rule 5101:1-38-02 of the Administrative Code addresses acceptable citizenship documentation only.

5101:1-38-02.1 Medicaid: Social Security number requirements
This rule is rescinded. The Social Security number requirement is found in new rule 5101:1-38-01.8 of the Administrative Code.

5101:1-38-02.2 Medicaid and covered families and children Medicaid: automatic assignment of third party medical support payments, right of recovery of third party resources, and role of ODJFS and CDJFS regarding third party resources.
This rule is being rescinded. Assignment requirements are located in new rule 5101:1-38-01.8 of the Administrative Code and administrative agency responsibilities are located in new rule 5101:1-38-01 of the Administrative Code, which is addressed in MEMTL 51.

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MEMTL 51 (Medicaid: Application Processing and Definitions)

Medicaid Eligibility Manual Transmittal Letter No. 51

September 24, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Application Processing and Definitions

This MEMTL contains one rule from Chapter 5101:1-37 and two rules from Chapter 5101:1-38 of the Administrative Code, adopted under section 111.15 of the Revised Code. These rules replace six rescinded rules from these same Chapters. The rules were reviewed in accordance with section 119.032 of the Revised Code.

The effective date of these rules is October 1, 2009.

Chapter 1


Existing OAC rule 5101:1-37-01 "Medicaid: Introduction and Definition of Program" is rescinded and replaced with this new rule, which lists definitions that apply generally across all medical assistance programs. As other rules are amended or replaced, additional definitions will be added to this rule. Eventually, only terms that are defined differently in a specific rule will be listed in a definitions section of another rule.


This rule is rescinded. The language in this rescinded rule is incorporated into OAC rule 5101:1-38-01 "Medicaid: individual and administrative agency responsibilities".

Chapter 2

5101:1-38-01 Medicaid: individual and administrative agency responsibilities.

This rule is rescinded and replaced with a new rule that sets out responsibilities of the individual and the administrative agency that apply at all times - at application; at the initial eligibility determination; at a scheduled or unscheduled redetermination; and between redeterminations. Parts of the existing rule that applied to the application or reapplication process are moved to new OAC rule 5101:1-38-01.2 "Medicaid: application, determination, and redetermination processes".

Some of the notable inclusions or changes in this rule include the following.

- Paragraph (C)(3) of this new rule includes the provision that the county shall not approve medical assistance to an individual merely because of an agency error or delay in determining eligibility, unless all eligibility factors are met.
- Paragraph (C)(4) requires that the county not delay a determination of an individual's eligibility for Medicaid while waiting for verifications or information that are only needed to determine eligibility for other programs.
- Paragraph (C)(11) is an ongoing requirement that the county document its determinations and decisions. This ongoing requirement will replace the current redundant practice of including the notice requirement in any rule that requires that a county make a determination.
- Similarly, paragraph (C)(16) is an ongoing requirement that the county issue notice of all of its decisions. This requirement takes the place of the current redundant notice requirements in any rule that requires that a county make a determination.

5101:1-38-01.1 Medicaid: pre-termination review (PTR) of continuing Medicaid eligibility.

This rule is rescinded, and its requirements are integrated into new OAC rule 5101:1-38-01.2 "Medicaid: application process". In the new rule, this process is simplified and reorganized for clarity.
Medicaid: application, determination, and redetermination processes.

This rule is rescinded and replaced with a new rule that more clearly reflects the actual application process, including parts of the process previously included in rules 5101:1-38-01 and 5101:1-38-01.1 of the Administrative Code.

Some of the notable inclusions or changes in this rule include the following.

- In paragraph (E)(1), a federally-based requirement that the county allow the person of the individual's choice to accompany and assist the individual. This is separate from the authorized representative provision in paragraph (E)(2). There is no minimum age - any person may accompany and assist the individual. This does not, however, mean that the county should not also provide a professional translator when appropriate.

- In paragraph (G) and its subparagraphs, face-to-face interviews are required only for consumers seeking Medicaid for the Aged, Blind, or Disabled, and only at the initial application.

- Paragraph (G)(1)(d)(i)(a) requires that a county consider a consumer's potential Medicaid eligibility even if the consumer completed the wrong Medicaid application for a specific program. If additional information is needed to determine a consumer's eligibility, additional information and verifications should be requested within the application timelines.

- Paragraph (G)(1)(f) requires that a county consider a consumer's potential eligibility for retroactive coverage. It is not necessary for a consumer to request this coverage, and no separate application is required. However, the JFS 07110 is still available to counties to assist with gathering information.

- Paragraph (G)(3) and its subparagraphs address periodic, scheduled redeterminations. As of the effective date of this rule, eligibility will be redetermined annually for all categories of Medicaid coverage. Cases currently in the system will be reviewed by the existing deadlines, but do not have to be redetermined again for 12 months.

- At redetermination, no face-to-face interview is required, no application is required, and nothing needs to be signed. The one exception is that a signature will be needed if no one who previously signed an application remains in the household. Counties may choose to make contact with consumers by phone, by mail, by fax, or in person to collect the necessary information to make an eligibility determination. The consumer is still obligated to verify information at redetermination and when a case change affects eligibility.

- Paragraph (I) sets out the requirement for a pre-termination review (PTR) before terminating a consumer's Medicaid benefits for any reason.

Medicaid and Covered Families and Children Medicaid (CFC): Retroactive Coverage.

This rule is rescinded, and its requirements are integrated into new OAC rule 5101:1-38-01.2, Medicaid: application process. In the new rule, this requirement is simplified and reorganized for clarity.

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MEMTL 50 (Medicaid: Assisting Individuals Unable to Access Verifications Due to a Physical or Mental Impairment)

Medicaid Eligibility Manual Transmittal Letter No. 50
June 30, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Assisting Individuals Unable to Access Verifications Due to a Physical or Mental Impairment

This MEMTL contains one new rule from Chapter 5101:1-38 of the Administrative Code. Rule 5101:1-38-01.7 "Medicaid: Assisting Individuals Unable to Access Verifications Due to a Physical or Mental Impairment" is a new rule adopted under section 111.15 of the Revised Code.

The effective date of this rule is August 1, 2009.

Chapter 2
5101:1-38-01.7 Medicaid: Assisting Individuals Unable to Access Verifications Due to a Physical or Mental Impairment

This new rule instructs county departments of job and family services regarding how to assist individuals who are attempting to apply for Medicaid or access their own resources for self-support, but who have a physical or mental impairment which may be creating an obstacle to the application process or to accessing means of self-support.

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MEMTL 48 (Refugee Medical Assistance)
Medicaid Eligibility Manual Transmittal Letter No. 48
May 1, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Refugee Medical Assistance


The effective date of this rule is May 7, 2009.

Chapter 5
5101:1-42-90 Refugee Medical Assistance (RMA)

The purpose of this new rule is to set forth the eligibility requirements for refugees to qualify for the RMA program. Changes include making the rule more consistent with Medicaid rules, adding definitions, simplifying language, and adding Iraqi and Afghan special immigrants. Also, the RMA eligibility period for Afghan special immigrants is now extended from six months to eight months.

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MEMTL 47A (Medicaid: Suspension of Payment for Services)

Medicaid Eligibility Manual Transmittal Letter No. 47A

May 27, 2009

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Suspension of Payment for Services

Amended Substitute H.B. 215 of the 127th General Assembly mandates individuals in public institutions, who were in receipt of Medicaid, shall have benefits suspended and then reinstated, upon release. This provides individuals with access to healthcare and medications necessary to function and maintain their health, thereby reducing the rate of recidivism caused by lack of immediate access to healthcare and medications.

These rules are effective on May 29, 2009.

Chapter 1


This is a new rule specifying when payment for services is not available to an individual eligible for Medicaid. The rule also clarifies when the administrative agency shall suspend payment for Medicaid services.


This rule is rescinded and made new stating an individual who resides in Ohio meets the living arrangement requirement for Medicaid eligibility purposes. The rule also points to rule 5101:1-37-20 of the Administrative Code, describing when payments for services are not available to individuals receiving Medicaid.

Chapter 4


This rule is being rescinded because it duplicates information contained in rule 5101:1-39-04 of the Administrative Code.

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Amended Substitute H.B. 215 of the 127th General Assembly mandates individuals in public institutions, who were in receipt of Medicaid, shall have benefits suspended, and then reinstated, upon release. This provides individuals with access to healthcare and medications necessary to function and maintain their health, thereby reducing the rate of recidivism caused by lack of immediate access to healthcare and medications.

These rules were effective on an emergency basis March 1, 2009. If no revisions are made to the proposed rules prior to the finalization by JCARR, the regular filing will become effective on a permanent basis on or about May 29, 2009.

**Chapter 1**

**Medicaid: 5101:1-37-20 Restrictions on Payments for Services.**

This is a new rule specifying when payment for services is not available to an individual eligible for Medicaid. The rule also clarifies when the administrative agency shall suspend payment for Medicaid services.

**Medicaid: 5101:1-39-04 Living Arrangement Requirement.**

This rule is rescinded and made new stating an individual who resides in Ohio meets the living arrangement requirement for Medicaid eligibility purposes. The rule also points to rule 5101:1-37-20 of the Administrative Code, describing when payments for services are not available to individuals receiving Medicaid.

**Chapter 4**

**Medicaid: 5101:1-40-09 Covered Families and Children Medicaid: Living Arrangements.**

This rule is being rescinded because it duplicates information contained in rule 5101:1-39-04 of the Administrative Code.

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MEMTL 45 (5101:1-38-02 Medicaid: Verification and Reporting Requirements)

Medicaid Eligibility Manual Transmittal Letter No. 45
June 24, 2008

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: 5101:1-38-02 Medicaid: Verification and Reporting Requirements

This Medicaid Eligibility Manual Transmittal Letter amends rule 5101:1-38-02 of the Administrative Code to include additional documents for both birthplace/nationality and identity, as well as adding provisions for verification of U.S. citizenship for naturalized citizens.

Also, the amended rule refers the CDJFS to section 5111.11 of the Revised Code. As amended, this rule is not subject to a five-year rule review. The effective date of this rule is July 1, 2008.

Chapter 2
Medicaid: 5101:1-38-02 Verification and Reporting Requirements.
The amended rule references clarification and changes made by the federal government for verification of U.S. citizenship which provided clarification and added new documents.

The amended rule references clarification and changes made by the federal government. The Deficit Reduction Act of 2005 required verification of U.S. citizenship for all applicants and recipients of Medicaid, except for those individuals already enrolled in any part of Medicare, or in receipt of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), IV-B foster care, IV-E foster care maintenance or adoption assistance.

Effective July 13, 2007, changes in federal guidance allow for naturalized citizens to use either citizenship documentation (a U.S. passport, naturalization papers, or a Certificate of U.S. Citizenship) or a combination of birthplace/nationality documents and identity documents, including the use of the Systematic Alien Verification for Entitlements (SAVE) data verification system, when accompanied by an acceptable form of identification.

Additional acceptable documentation for birthplace/nationality includes: data verification with the SAVE; evidence showing an individual meets the requirements of the Child Citizenship Act of 2000; an official religious record, recorded in the U.S. within three months of birth; an early school record showing a U.S. place of birth, which shows the name of the individual, the date of admission to the school, the date of birth, a U.S. place of birth, and the names and places of birth for the individual's parents; and The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

Additional acceptable documentation for identity includes: the use of three or more corroborating documents; affidavits for individuals residing in residential care facilities; affidavits of identity for children ages 16 to 18 years; and for children under age sixteen, the use of a clinic, doctor or hospital record.

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Am. Sub. H.B. 119 authorized two new Medicaid eligibility groups for persons who are disabled and want to work. Medicaid Buy-in for Workers with Disabilities allows certain individuals with disabilities the opportunity to increase their earned income and resources without losing health care coverage.

This Medicaid Eligibility Manual Transmittal Letter (MEMTL) contains rule 5101:1-41-30 of the Administrative Code, "Medicaid buy-in for workers with disabilities (MBIWD)" as well as form JFS 07211, "Medicaid Buy-In for Workers with Disabilities (MBIWD) Addendum".

Effective date: April 1, 2008

Chapter 5

5101:1-41-30 Medicaid: Medicaid Buy-In for Workers with Disabilities (MBIWD)

Rule 5101:1-41-30 of the Administrative Code implements two new Medicaid eligibility groups: (1) MBIWD basic coverage group and (2) MBIWD medically improved coverage group. Individuals in these two coverage groups are considered a group of one for purposes of determining or redetermining eligibility. The key factors for MBIWD eligibility are as follows:

Individuals eligible for the MBIWD basic coverage group must:

- Meet the citizenship requirements outlined in rule 5101:1-38-02.3 of the Administrative Code;
- Be a resident of Ohio;
- Be at least sixteen and less than sixty-five years of age;
- Be disabled as defined by the Social Security Administration (SSA) for purposes of the federal Supplemental Security Income program (SSI), except employment activity, earnings, and substantial gainful activity must not be considered when determining disability for MBIWD;
- Have countable income (after disregards) and countable resources within specified limits;
- Pay a premium, if applicable; and,
- Be working.

Individuals eligible for the MBIWD medically improved group must:

- Have been eligible for the MBIWD basic coverage group in the previous calendar month, and continue to meet all eligibility criteria except the disability criterion; and
- Be working at least forty hours per month earning at least the state or federal minimum wage, whichever is lower.

The MBIWD program considers only an individual's own resources. If resources are jointly owned, determine the value of the individual's countable resources under rules 5101:1-39-05 and 5101:1-39-26. To be resource-eligible for the MBIWD program, an individual must have no more than $10,000 in countable resources.

CRISE should correctly calculate an MBIWD individual's income. To be eligible for the MBIWD program, a consumer's income (after the relevant disregards) must not exceed 250% of the Federal Poverty Level (FPL) for one person. The exemptions and disregards in rule 5101:1-39-18 do apply in the MBIWD program, but in a slightly different order. If the resulting income after the applicable disregards in rule 5101:1-39-18 exceeds 250% FPL for one person, an additional deduction is taken from earned income each month to bring the individual's income down to 250% FPL. This additional deduction is limited to $20,000 per year, can only be
taken from earned income, and can be deducted from previous earnings if retroactive eligibility is being explored. Once an additional $20,000 in a year (beginning from the first month of eligibility) has been disregarded, unless the individual reports a drop in income, the individual will be over income for the MBIWD program until a year (from the first month of eligibility) has passed and the consumer is eligible for a new $20,000 annual earned income disregard.

Calculating the premium (and determining whether the individual must pay a premium) involves several financial calculations. A premium calculator will be available on the innerweb.

Eligibility for the MBIWD program (whether it is prospective or retroactive eligibility) begins no earlier than the program's April 1, 2008, start date.

**Forms**

**JFS 07211 Medicaid Buy-In for Workers with Disabilities (MBIWD) Addendum**

The MBIWD addendum form, JFS 07211, is designed to be used with the JFS 07200 "Request for Cash, Food Stamp, and Medical Assistance" application. The addendum should be accepted and processed on or after April 1, 2008. The JFS 07211 is not an application for cash assistance, regular Medicaid, food stamps, or waiver assistance.

The JFS 07211 may be used for mail-in or face-to-face interviews for MBIWD. A face-to-face interview is optional, at the consumer's request, but should never be required by the CDJFS.

Applications for MBIWD should be processed in accordance with OAC 5101:1-38-01.2 and 5101:1-41-30. There is no potential for eligibility before the program's April 1, 2008, start date.

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MEMTL 41 (Medicaid: Children in Care and Individuals Younger than Age Twenty-One Who Have Aged Out of Foster Care)

Medicaid Eligibility Manual Transmittal Letter No. 41

Family, Children And Adult Services Procedure Letter No. 134

January 1, 2008

To: Medicaid Eligibility Manual Holders
    Family, Children and Adult Services Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: Children in Care and Individuals Younger than Age Twenty-one Who Have Aged Out of Foster Care.

House Bill 119 of the 127th General Assembly establishes that youth who have aged out of foster care and meet all eligibility requirements are eligible for Medicaid until they reach age twenty-one. This rule was reviewed in accordance with section 119.032 of the Revised Code.

This Letter contains rule 5101:1-40-03 of the Administrative Code, "Medicaid: children in care and individuals younger than age twenty-one who have aged out of foster care" which is now the rule for all children in care and includes the Medicaid expansion for aged out foster care youth to age twenty-one.

Also included are rescinded rules 5101:1-40-03 "Covered families and children (CFC) medicaid: children in care", 5101:1-40-02.3 "Covered families and children medicaid: coverage for foster care maintenance and adoption assistance money payment recipients", and 5101:1-40-10 "Covered families and children Medicaid: county case responsibility for individuals in custody of public children services and private child placing agencies". Attached is the revised form JFS 01958 "Referral for Medicaid Continuing Eligibility Review".

The effective date is January 1, 2008.

Chapter 4 of the Medicaid Eligibility Manual

5101:1-40-03 Medicaid: children in care and individuals younger than age twenty-one who have aged out of foster care.

This rule is changed to reflect the expanded coverage for youth aging out of foster care. Youth must be in foster care at age 18 and must have received Title IV-E services before age 18. There is no resource or income test, and no face to face interview is required. PCSA staff must use the JFS 01958 "Referral for Medicaid Continuing Eligibility Review" to provide information to the CDJFS in order to explore eligibility for this new category.

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MEMTL 38 (Medicaid: Qualified Long-Term Care Partnership and Estate Recovery)

Medicaid Eligibility Manual Transmittal Letter No. 38
August 15, 2007

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Qualified Long-Term Care Partnership and Estate Recovery


Effective date: September 1, 2007

Chapter 2
Medicaid estate recovery 5101:1-38-10

This rule is rescinded and made new to reflect the implementation of changes in O.R.C. section 5111.11. The Revised Code expanded the population subject to Medicaid estate recovery to include individuals who are permanently institutionalized (in a nursing or medical institution, not receiving community-based Medicaid). The assets subject to recovery have also been broadened to include non-probate assets. An Undue Hardship Waiver process has been created and identified in the rule. The rule also includes new provisions related to the Qualified Long Term Care Partnership.

Medicaid: qualified long term care partnership 5101:1-38-11

This new rule defines the QLTCP program under O.R.C. section 5111.18. To be a "Partnership policy," a long term care policy must meet specific criteria: the Ohio Department of Insurance has the responsibility of determining whether a policy meets those criteria. A consumer with a Partnership policy receives a resource disregard ("QLTCP disregard") -- after a resource assessment and allocation -- equal to the amount of the benefits that have been paid to date by the Partnership policy to or on behalf of that consumer. This QLTCP disregard may also be applied to transferred resources that might otherwise trigger a Restricted Medicaid Coverage Period. However, the total QLTCP disregard applied can never exceed the total amount of benefits actually paid by the Partnership policy to or on behalf of the consumer.

Chapter 3

This rule has been amended to clarify that a QLTCP disregard cannot be used to offset or reduce the home equity restriction in paragraph (C)(5) of this rule.

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MEMTL 36 (Medicaid: Voter Registration Requirements)

Medicaid Eligibility Manual Transmittal Letter No. 36

May 18, 2007

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Voter Registration Requirements

This Medicaid Eligibility Manual Transmittal Letter (MEMTL) amends rule 5101:1-38-01.2 of the Administrative Code. This proposed change will direct CDJFS' to the voter registration process maintained in rule 5101:1-2-15 of the Administrative Code, as required by section 3503.10 of the Revised Code and by the National Voter Registration Act of 1993. Also, the amended rule refers the CDJFS to section 5111.11 of the Revised Code. As amended, this rule is not subject to a five-year rule review. The effective date of this rule is June 1, 2007.

Chapter 2


The amended rule references voter registration requirements outlined in the Office of Family Stability's voter registration requirements rule. Specifically, rule 5101:1-38-01.2 of the Administrative Code is amended at paragraph (C)(6)(b)(xxii) to reference rule 5101:1-2-15 of the Administrative Code. Also, other changes in paragraph (C) include correcting four revision dates on forms.

In addition to the revision date changes, the JFS 07400 "Ohio Medicaid Estate Recovery" form, revised June 2007, modifies estate recovery language to comply with changes made to estate recovery by Substitute Amended House Bill 66.

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MEMTL 35 (Medicaid: Deficit Reduction Act of 2005)

Medicaid Eligibility Manual Transmittal Letter No. 35

November 13, 2006

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Deficit Reduction Act of 2005

The Ohio Department of Job and Family Services (ODJFS) reviewed this rule in accordance with Section 119.032 of the Ohio Revised Code (ORC). Rule 5101:1-39-24 of the Ohio Administrative Code (OAC) is rescinded under Section 119.03 of the ORC and the new rule is promulgated under 111.15.

This MEMTL contains one rule from Chapter 5101:1-39-24 of the OAC. The new rule clarifies the federal budget requirements contained in the Deficit Reduction Act of 2005.

The effective date of this MEMTL is December 1, 2006.

Chapter 3


This rule is rescinded and made new to define the treatment of income in determining patient liability for individuals receiving long-term care (LTC) services in a LTC facility, under an HCBS waiver, or under PACE. This rule requires an income-first approach before allocating additional resources to the community spouse. All available income of the institutionalized spouse must be considered before allocating additional resources to the community spouse.

Significant changes to this rule include:

- A reformatted definition for the Minimum Monthly Maintenance Needs Allowance (MMMNA), in paragraph (B);
- Clarification regarding the treatment of veteran's reduced pension, in paragraph (C);
- Clarification to the Monthly Income Allowance (MIA) calculation, in paragraph (C)(2)(d);
- Clarification regarding the treatment of a Personal Needs Allowance (PNA) when determining patient liability (C)(2)(c); and
- An exclusion of the date of death or date of discharge from the prorated payment calculation in paragraph (C)(2)(i)(ii).

The following forms are revised and effective October 1, 2006:

**JFS 04078** "Monthly Income Allowance Computation Worksheet" (Revised 10/06) The CDJFS completes this worksheet when determining the amount of income the community spouse is entitled to receive from the institutionalized spouse as a monthly income allowance; the worksheet is then provided to the consumer. This form has also been reformatted for clarity.

**JFS 07332** "Notice of Denial of Your Application for Medicaid in Cases Involving a Community Spouse" (Revised 10/06) Language has been added to inform the consumer about requesting a state hearing when there is a need for a reallocation of the couple's resources due to insufficient income to generate the full amount of the monthly income allowance.

The following form is new and effective October 1, 2006:

**JFS 07139** "Medicaid APPROVAL Notice in Cases with A Community Spouse" (10/06) The CDJFS uses this form to notify the consumer of the approval of a Medicaid application for LTC services. This form is used along with the JFS 04076, JFS 04077, and JFS 04206, as appropriate.

Desk aids and presentations are available in the eManual Contents section of the Medicaid Eligibility Manual (MEM).
MEM Instructions:

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**ODJFS Electronic Manuals:**
http://emanuals.odjfs.state.oh.us/emanuals

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http://www.odjfs.state.oh.us/lpc/calendar/
MEMTL 34 (Medicaid: Transfer of Resources Forms)

Medicaid Eligibility Manual Transmittal Letter No. 34

October 17, 2006

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Transfer of Resources Forms

The Ohio Department of Job and Family Services (ODJFS) reviewed these rules in accordance with Section 119.032 of the Ohio Revised Code (ORC).

The new rule sets forth the federal budget requirements contained in the Deficit Reduction Act of 2005. This MEMTL contains one rule from Chapter 5101:1-39 of the Ohio Administrative Code (OAC) and seven forms.

The effective date of the rule is October 20, 2006.
The effective date of the forms is October 1, 2006.

Chapter 2 Application Processing

The following optional forms are new.

JFS 07111 "Notice of New Citizenship Requirement for Medicaid" (10/06)
This form is optional and the CDJFS can use this form to notify the consumer that due to a change in their case information, the CDJFS now needs the consumer to provide proof of U.S. citizenship.

JFS 07405 "Third Party Affidavit of Birthplace or Nationality" (10/06)
This form is optional and the CDJFS can use this form to be completed by at least two individuals who have personal knowledge of the event(s) establishing the applicant/recipient's claim of U.S. citizenship.

JFS 07407 "Affidavit of Identity for a Child Age 16 Years or Less" (10/06)
This form is optional and the CDJFS can use this form to be completed by the parent/guardian for a child age 16 years or less as identity documentation of the child.

Chapter 3 Aged, Blind, and Disabled (ABD)

5101:1-39-07 Medicaid: Transfer of Resources
This rule is new and replaces 5101:1-39-07 Medicaid: transfer of resources which defines the treatment of a transfer of resources. The rule format was revised to be consistent with other new rules in the Medicaid Eligibility Manual (MEM). Other revisions include:

- Language extending the look-back period to sixty months.
- For improper transfers made on or after February 8, 2006, restricted Medicaid coverage period begins on the first day of the month during or after which assets were transferred for less than fair market value, or the date the individual is eligible for medical assistance and would otherwise be receiving LTC services in a LTC facility, HCBS waiver, or PACE, whichever is later.
- For improper transfers made on or after February 8, 2006, language has been added to calculate the restricted Medicaid coverage period. This rule includes new language which prohibits rounding down or disregarding any fractional restricted Medicaid coverage periods.
- Language has been added to clarify the undue hardship process and to give the facility the authority to request an undue hardship for the resident.
- The CDJFS is responsible to notify the individual of the undue hardship and of the decision to grant an undue hardship exception.
Undue hardship does not permit an individual to receive LTC services while the hardship decision is pending.

The individual and the nursing facility must exhaust all legal remedies to compel the return of the asset before the individual can qualify for an undue hardship.

The following forms are new and effective October 1, 2006.

**JFS 04027 "Restricted Medicaid Coverage Period Determination" (10/06)**

The CDJFS uses this budgeting worksheet to provide the consumer with information regarding the determination of the period of time an institutionalized individual is subject to a restricted Medicaid coverage period due to an improper transfer of resources. This form provides a budget method for improper transfers that occurred on or after February 8, 2006.

**JFS 07138 "Notice of Approval of Your Application for Medicaid with Restricted Coverage" (10/06)**

Additional language is added regarding the five hundred thousand dollar home equity disqualification for coverage of LTC services. Undue hardship language has also been added.

**JFS 07140 "Availability of Hardship Exemption" (10/06)**

The CDJFS sends this notice to the consumer detailing the right to request a hardship exemption when a determination has been made that the individual is not eligible for LTC services due to either an improper transfer of resources or home equity in excess of five hundred thousand dollars. A hardship may occur if the imposition of a restricted coverage period would deprive the consumer of medical care such that the individual's health or life would be endangered.

**JFS 07141 "Decision on Your Request for a Hardship Exemption" (10/06)**

The CDJFS uses this form to notify the consumer of the decision made on their request for a hardship exemption. Hearing rights are also included on the form.

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http://emanualstest.odjfs.state.oh.us/emanuals/

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Internet Calendar:

http://www.odjfs.state.oh.us/lpc/calendar/
MEMTL 33 (Medicaid: Deficit Reduction Act of 2005)

Medicaid Eligibility Manual Transmittal Letter No. 33

October 11, 2006

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Deficit Reduction Act of 2005

The Ohio Department of Job and Family Services (ODJFS) reviewed these rules in accordance with Section 119.032 of the Ohio Revised Code (ORC).

The new and amended rules sets forth the federal budget requirements contained in the Deficit Reduction Act of 2005 and state budget requirements contained in Amended Substitute House Bill 66. This MEMTL contains eighteen rules: one rule from Chapter 5101:1-38 of the Ohio Administrative Code (OAC); sixteen rules from Chapter 5101:1-39 of the OAC; and, one rule from Chapter 5101:1-41 of the OAC.

The effective date of this MEMTL is October 1, 2006.

Chapter 2
5101:1-38-01.2 Medicaid: Application process.

This rule is new and replaces 5101:1-38-01.2 Medicaid: application process to add annuity disclosure language requiring Medicaid applicants and some recipients of long term care (LTC) services, a home and community-based services (HCBS) waiver, or the program of all inclusive care for the elderly (PACE) to name the State of Ohio remainder beneficiary of the annuity. Additional changes to the rule include the following:

- References to the JFS 07100 "Application for Income, Medical, and Food Assistance" (also known as the "common application form" (CAF)) have been removed.
- 19 and 20 year olds can now use the JFS 07216 "Combined Programs Application" (CPA) to apply for Medicaid. Also, a face-to-face interview is no longer required for 19 and 20 year olds.
- A face-to-face interview must be scheduled within 10 days of the receipt of an application for medical assistance.
- A legal entity can be an authorized representative. Also, the administrative agency may request proper identification from the authorized representative.
- Individuals who knowingly make or cause a false or misleading statement to be made, conceal an interest in property, or fail to disclose a transfer of property may be guilty of Medicaid eligibility fraud.
- Reorganizing and formatting for clarification. References to automated systems have been removed.

Chapter 3

This rule is new and replaces 5101:1-39-02.2 Medicaid: aged, blind or disabled philanthropic long-term care facility medicaid assistance groups to include language regarding the treatment of entrance fees as countable resources for individuals residing in continuing care retirement communities and life care communities.


This rule is new and replaces 5101:1-39-05 Medicaid: resource requirement to include language regarding the treatment of entrance fees as countable resources for individuals residing in continuing care retirement communities and life care communities, as outlined in OAC rule 5101:1-39-02.2.

This rule is new and replaces 5101:1-39-08 Medicaid: income to add definitions, formatting revisions, and language clarifications. Additional changes include:

- Adding clarification that deductions due to a repayment of an overpayment, loan or other debt is not considered income if the amount being withheld was included when determining the amount of unearned income for a previous month.

- In the determination of medical assistance eligibility, court-ordered deductions are still considered as income to the individual.

- Child support payments made to an individual on behalf of an adult child is not considered income unless the individual retains the income and does not give it to the adult child.

- Liens are not an allowable deduction from income.

### 5101:1-39-22.7 Medicaid: Retirement and income supplementing accounts (RISAs).

This rule is amended to include a reference to the annuity requirements as outlined in OAC rule 5101:1-39-22.8.

### 5101:1-39-22.8 Medicaid: The disclosure and treatment of annuities for recipients or applicants for long term care services.

This rule is new and replaces 5101:1-39-22.8 Medicaid: annuities to specify the annuity disclosure requirements and remainder beneficiary designations for any annuity purchased by individuals applying for LTC services, HCBS waivers, or PACE. The State must be named as the remainder beneficiary in the first position, or in the second position after the spouse or minor child or disabled child of any age. This rule also addresses the purchase of an annuity with funds from a retirement account (i.e. RISA). The purchase of an annuity will be considered an improper transfer unless the purchase meets specific criteria as outlined in this rule. This rule also provides guidance for annuities purchased prior to February 8, 2006. The life expectancy tables have been removed from the rule.


This rule is new and replaces 5101:1-39-26 Medicaid: resource exemptions to include new language referring to the principal place of residence in OAC rule 5101:1-39-31. The following exempt resources not previously listed in the rule have been added:

- Certain prepaid burial contracts.
- Interest in trust or restricted lands if the individual or spouse is of Native American Indian descent.
- Assistance received as a result of a catastrophe declared by the President of the United States as a major disaster, victims of crime funds, or relocation assistance.
- Grants, scholarships and gifts used to pay tuition, fees and other necessary educational expenses.
- Funds received from the Ricky Ray Hemophilia Relief fund.

Language has also been added to address interest earned on different types of funds and how this interest affects eligibility. Other changes include formatting and the addition of definitions of terms.


This rule is new and replaces 5101:1-39-27.1 Medicaid: trusts to include language defining the treatment of trusts for the purpose of determining eligibility for medical assistance programs. The look-back period for all trusts is extended to 60 months.


This rule is new and replaces 5101:1-39-27.3 Medicaid: promissory note, mortgages, stocks and bonds to address the treatment of funds used to purchase promissory notes, mortgages, and loans as assets. Funds used to purchase these items may be considered an improper transfer of assets unless the items have a repayment term that is actuarially sound, provides for payments in equal amounts with no deferrals or balloon
payments, and prohibits the cancellation of the balance upon the lender's death. These items are still considered an available asset when determining eligibility for medical assistance.

This rule is new and replaces 5101:1-39-30 Medicaid: life insurance to include a reference to the annuity requirements as outlined in OAC rule 5101:1-39-22.8. Additional formatting changes are added and definitions are revised. The cash surrender value table has been removed from the rule.

This new rule combines rescinded OAC rules 5101:1-39-31.1 and 5101:1-39-31.2. This rule specifies that an individual with home equity interest in excess of five hundred thousand dollars is not eligible for LTC services, HCBS waivers, or PACE; however, the individual may still be eligible for Medicaid. Exceptions to the five hundred thousand dollar home equity disqualification are listed in this rule. The home equity limit applies to individuals:

- Applying for Medicaid and LTC services, HCBS waivers or PACE on or after January 1, 2006.
- In receipt of Medicaid prior to January 1, 2006, who apply for LTC services, HCBS waiver, or PACE on or after January 1, 2006.
- In receipt of Medicaid and LTC services, HCBS waivers or PACE prior to January 1, 2006, who have had a break in LTC services, HCBS waivers or PACE on or after January 1, 2006.

Information on the availability of an undue hardship exemption has been added.

As a result of Amended Substitute House Bill 66, the homestead property exemption is extended from six to thirteen months for individuals residing in a nursing facility. The homestead exemption begins when the individual is institutionalized and is eligible for Medicaid.

This rule is rescinded and the language in this rescinded rule is incorporated into OAC rule 5101:1-39-31.

This rule is rescinded and the language in this rescinded rule is incorporated into OAC rule 5101:1-39-31.

This rule is new and replaces 5101:1-29-32 Medicaid: life estates and life leases to add language regarding the purchase of a life estate interest in another individual's home. The purchase of a life estate interest in another individual's home may result in the determination of an improper transfer of assets if the individual does not reside in the home in which he or she owns the life estate for at least 12 months. The individual must also purchase the life estate for fair market value. The life estate may also be considered an available resource. Additional formatting changes are added and definitions are revised.

This rule is amended to add definitions of terms used in the rule.

This rule is new and replaces 5101:1-39-35 Medicaid: resource assessment to clarify when a resource assessment must be completed. Changes to the rule include:

- Completing a resource assessment based on the date of marriage if an institutionalized individual marries someone in the community.
- Completing one resource assessment based on each spouse’s first continuous period of institutionalization when either spouse is institutionalized.
- Accepting the date of the first continuous period of institutionalization that occurred out of state, but completing new resource assessment to determine if the individual is eligible under the OAC.
Formatting and the addition of definitions of terms used in the rule.


This rule is new and replaces 5101:1-39-36.1 Medicaid: resource budgeting methodology for institutionalized individuals with a spouse in the community to add language requiring that all available income of the institutionalized spouse must be allocated to the community spouse (income-first) before additional resources can be transferred to the community spouse through the state hearing process.

Chapter 5

5101:1-41-05 Breast and cervical cancer project (BCCP) Medicaid: Application and eligibility determination process.

This rule is amended to rescind the appendix containing the JFS 07161 "Ohio Breast and Cervical Cancer Project (BCCP) Medicaid Application". The form is available through the ODJFS Forms Central website.

The following form is revised and effective October 1, 2006:

JFS 04077 "Resource Transfer Worksheet" (Revised 10/06) This worksheet is used by the county department of job and family services (CDJFS) to determine the amount of resources the community spouse is entitled to retain when spousal impoverishment provisions apply. The form has been reformatted for clarity.

The following form is new and effective October 1, 2006:

JFS 04206 "Family Allowance (FA) and Family Maintenance Needs Allowance (FMNA) Computation Worksheet" (10/06) The CDJFS uses this budgeting worksheet to provide the consumer with information regarding the determination of the family allowance and family maintenance needs allowance. This form is used along with the JFS 07332 or JFS 07139, as appropriate.

The following forms are made obsolete:

JFS 04079 "Determination of Income and Resources Allocation" (Revised 03/03) The information on this form has been incorporated into the JFS 07138 and JFS 07139.

JFS 07135 "Medicaid Long Term Care Facility Information Worksheet" (Revised 01/90) This form was created to obtain information for the period January 1, 1990 through December 31, 1990.

Desk aids and presentations are available in the eManual Contents section of the Medicaid Eligibility Manual (MEM).

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MEMTL 32 (Medicaid: Verification Requirements)

Medicaid Eligibility Manual Transmittal Letter No. 32

September 28, 2006

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Medicaid: Verification Requirements

The Deficit Reduction Act (DRA) of 2005 imposes specific verification requirements on applicants for and recipients of Medicaid. The new verification responsibilities are:

- U.S. citizenship.
- Changes to annuities.

This rule was reviewed in accordance with section 119.032 of the Revised Code. The effective date of the rule is September 25, 2006.

Chapter 2

5101:1-38-02 Medicaid: Verification and Reporting Requirements.

Rule 5101:1-38-02 of the Administrative Code is a new rule that replaces rule 5101:1-38-02 of the Administrative Code. The new rule outlines the verification and reporting requirements for Medicaid, and includes:

- Requirements for verification of U.S. citizenship. Individuals declaring U.S. citizenship must provide either a citizenship document or a combination of a birth/nationality document and an identity document. A hierarchy of acceptable documents is included in the rule.
- A reasonable opportunity period for individuals to obtain the necessary verifications. The administrative agency must assist individuals in securing the verifications needed in establishing eligibility. Good cause language is added to establish criteria when an individual has not cooperated with providing verifications.
- The administrative agency's responsibility in recording the receipt of the documents in the case file and retaining copies.
- Individuals having an ownership interest in an annuity must identify any changes made to that annuity, including a transaction such as a change in beneficiary.

The following forms have been revised effective October 1, 2006:

JFS 07161 "Ohio Breast & Cervical Cancer Project Medicaid Application" (Revised 10/2006) This application is used by the consumer when applying for Breast and Cervical Cancer Medicaid through the Ohio Department of Health. The application is revised to ask whether the applicant is a U.S. citizen. The Rights and Responsibilities page is revised to add information about the requirement to provide proof of U.S. citizenship.

JFS 07216 "Healthy Start/Healthy Families Combined Programs Application" (Revised 10/2006) This application is used to apply for Healthy Start/Healthy Families Medicaid along with other programs. The application is revised to add information on the application checklist stating that proof of U.S. citizenship is required, if the consumer applying for Medicaid claims U.S. citizenship. The Rights and Responsibilities page is revised to add information about the requirement to provide proof of U.S. citizenship and cooperating with establishing paternity and third party medical support.

JFS 07220 "Healthy Start/Healthy Families Checklist" (Revised 10/2006) The CDJFS sends this notice to the consumer to request information before a determination of Healthy Start/Healthy Families eligibility can be made.
The CDJFS sends this follow-up notice to the consumer to request necessary information from the consumer before a determination of eligibility can be completed.

This form is revised so that its content is consistent with the JFS 07161 and JFS 07216 Rights and Responsibilities pages. Information is added to inform individuals of the requirement to provide proof of U.S. citizenship and to cooperate with the establishment of paternity and third party medical support.

Desk aids and presentations are available in the eManual Contents section of the Medicaid Eligibility Manual (MEM).

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**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
TO: Food Stamp Certification Handbook Holders  
Cash Assistance Manual Holders  
Medicaid Eligibility Manual Holders  

FROM: Barbara E. Riley, Director  

SUBJECT: Revisions to the "Request for Cash, Food Stamp, and Medical Assistance," JFS 07200  

**Reason for Changes**  
In order to comply with federal requirements outlined in the Deficit Reduction Act of 2005, the following changes are being made to the JFS 07200, "Request for Cash, Food Stamp, and Medical Assistance". The new Medicaid citizenship requirement in rule 5101:1-38-02 of the Administrative Code will be effective September 25, 2006. Utilization of the revised JFS 07200 should be used beginning on or after October 1, 2006.  

**Description of the Revisions to the "Request for Cash, Food Stamp, and Medical Assistance, "JFS 07200**  

**Application Coversheet, Page Two, "What type of verification do I need?"**  
The first bullet immediately underneath the heading has been revised to read "If you are not a U.S. citizen and are only applying for alien emergency medical assistance, you do not have to verify your citizenship status or immigration status, or provide a social security number." Adding "or immigration status" will help to clarify that the individual does not have to provide INS documents for alien emergency medical assistance.  
The second line item of the verification chart has been revised to read "Permanent Resident Card ("green card") or other INS documentation if not a U.S. citizen" to use terminology commonly understood by applicants.  

Since proof of citizenship status is required for all individuals applying for any category of Medicaid and Cash Assistance Programs, "Proof of U.S. citizenship if a U.S. citizen" has been added as the third line item of the verification needed for Medical Assistance and Cash Assistance Programs.  

Annuities have been included on the seventh line item, "Proof of current value of stocks/bonds, certificates of deposit, life insurance, trusts, annuities. "  

**Page Two of the Application, Section Six: "Tell us about the people in your home"**  
The question "Are you married?" has been added under the chart requesting information about household members.  

**Page Three of the Application, Section Seven: "Tell us about your finances"**  
In the second question, annuities have been added as an example of resources that an assistance group may possess.  

**Page Four of the Application, Section Nine: "Signature of person who completed this application"**  
A statement has been added as the second bullet that attests that all annuities and other similar financial devices in which the assistance group has any interest have been reported by the applicant or the authorized representative.  

**Miscellaneous**
The Spanish and Somali versions of the JFS 07200 will be issued under separate cover at a later date.

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### INSTRUCTIONS: MEDICAL ELIGIBILITY MANUAL:

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MEMTL 30 (Medicaid: income and patient liability determinations for individuals under the assisted living home and community based waiver)

Medicaid Eligibility Manual Transmittal Letter No. 30

July 6, 2006

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Medicaid: income and patient liability determinations for individuals under the assisted living home and community based waiver.

House Bill 66 of the 126th General Assembly established a new Home and Community Based Services waiver to allow individuals to receive Medicaid services while residing in an assisted living facility. This new rule addresses the income, personal needs allowance and patient liability for those individuals.

Effective date: July 1, 2006

Chapter 3

Medicaid: income and patient liability determinations for individuals under the assisted living home and community based waiver.

Individuals who enroll in the new Assisted Living Waiver effective July 1, 2006 are required to contribute toward the cost of Medicaid services if their income is above a specific amount. These individuals are evaluated at the Special Income Limit (SIL), similar to the income evaluation of all other individuals who are enrolled in HCBS, PACE, or who are considered institutionalized in a long term care facility.

This companion rule (to rules 5101:1-39-23 and 5101:1-39-24) addresses only those differences in calculating income, personal needs allowance and patient liability for those enrolled in the Assisted Living Waiver. This rule references the other two rules and must be read in conjunction with the other rules.

Medicaid is prohibited by federal law from paying for room and board; therefore, instead of the special individual maintenance needs allowance or the personal needs allowance for institutionalized individuals, these consumers are allowed a special assisted living waiver maintenance needs allowance (ALMNA) designed to provide for room, board, and personal needs.

There are a total of 1800 waiver "slots" available to individuals on this waiver.

Eligibility requirements to enroll in the waiver after determination of Medicaid eligibility are addressed in new rules 5101:3-1-06.5 and 5101:3-33-02 to 5101:3-33-07 of the Administrative Code which are effective on July 1, 2006.

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This information is also available on the Internet and may be accessed at:

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MEMTL 29 (Medicaid: Social Security Number Requirement)

Medicaid Eligibility Manual Transmittal Letter No. 29

May 19, 2006

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Medicaid: Social Security Number Requirement.

This MEMTL contains rule 5101:1-38-02.1 of the Administrative Code, "Medicaid: Social Security number requirement". This new rule replaces rule 5101:1-38-021 of the Administrative Code. The rule was reviewed in accordance with section 119.032 of the Revised Code.

Effective date: July 1, 2006

Chapter 2

Medicaid: Social Security Number Requirement - 5101:1-38-02.1

Rule 5101:1-38-02.1 of the Administrative Code is a new rule that more closely reflects the language as outlined in the Code of Federal Regulations (CFR) regarding the requirement for individuals applying for medical assistance to provide a Social Security number.

The policy regarding the Social Security number requirement has not changed. Medicaid policy requires individuals applying for medical assistance to provide a Social Security number. Therefore, an individual applying on behalf of another individual, or other household members who are listed on the medical assistance application do not have to provide a Social Security number unless they are applying for medical assistance for themselves.

New federal language is added to paragraph (C)(3) requiring the administrative agency to assist an individual in completing an application for a Social Security number in certain situations. To assist administrative agencies in implementing this requirement, the internet link for the Social Security card application is listed at:


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MEMTL 28 (Medicaid: Healthy families eligibility change from 100% federal poverty level (FPL) to 90% FPL)

Medicaid Eligibility Manual Transmittal Letter No. 28
December 29, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Healthy families eligibility change from 100% federal poverty level (FPL) to 90% FPL

This MEMTL contains five rules from Chapter 5101:1-40 of the Administrative Code that were amended to implement the 2006-2007 budget initiative that reduced the Healthy Families parental eligibility from one-hundred percent to ninety percent of the federal poverty level. These changes were initiated by Am. Sub. HB 66 of the 126th General Assembly. These rules were also reviewed in accordance with Section 119.032 of the Revised Code.

The effective date of this MEMTL is: January 1, 2006.

Chapter 4

5101:1-40-02.1 "Covered families and children medicaid: low-income families (LIF) and OWF"
This rule was amended to reflect the ninety percent eligibility FPL standard for parents and to correct OAC references.

5101:1-40-20.4 "ADC-related medicaid: earned income"
This rule was amended to change CDHS references to CDJFS and JTPA references to WIA and to reflect the ninety percent eligibility FPL standard for parents.

5101:1-40-22 "Covered families and children (CFC) medicaid: allocating income to members of an assistance group"
This rule was amended to reflect the ninety percent eligibility FPL standard for parents.

5101:1-40-25 "Covered families and children medicaid: low income families medicaid (LIF) budgeting methodologies"
This rule was amended to change CDHS references to CDJFS, remove an inaccurate OAC reference, and to reflect the ninety percent eligibility FPL standard for parents.

5101:1-40-26 "Medicaid: standards of need and pregnancy allowance"
This rule was amended to reflect the ninety percent eligibility FPL standard for parents and to correct a misspelled word.

Effective January 1, 2006, income eligibility for healthy families Medicaid cannot exceed 90% of the FPL. The 90% FPL standard shall be used on all applications received and eligibility redeterminations completed on or after January 1, 2006. For all applications received and for eligibility redeterminations completed prior to January 1, 2006, the 100% FPL standard must be applied.

Two new reason codes must be used when denying or terminating any healthy families Medicaid application due to income exceeding 90% of the FPL. These codes will become effective on January 1, 2006, when the new poverty standard can be applied to new applications and redeterminations. The new reason codes and the 90% federal poverty level dollar figures are located in Medicaid Eligibility Procedure Letter No. 6, issued on November 28, 2005.

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MEMTL 27 (Medicaid: outstationing workers at disproportionate share hospitals and federally qualified health centers)

Medicaid Eligibility Manual Transmittal Letter No. 27

November 30, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: outstationing workers at disproportionate share hospitals and federally qualified health centers.

The Ohio Department of Job and Family Services (ODJFS) reviewed this rule in accordance with section 119.032 of the Revised Code. This MEMTL contains one rule of the Administrative Code: 5101:1-38-04 "Medicaid: outstationing workers at disproportionate share hospitals and federally qualified health centers."

This new rule clarifies the administrative agency's role in facilitating outreach services for pregnant women and children through the process of outstationing at disproportionate share hospitals and federally qualified health centers.

The effective date of this MEMTL is: January 1, 2006.

Chapter 2

5101:1-38-04 Medicaid: outstationing at disproportionate share hospitals and federally qualified health centers.

Rule 5101:1-38-04 of the Administrative Code is a new rule that replaces rule 5101:1-38-04 of the Administrative Code. Rule 5101:1-38-04, with an effective date of 07/01/2000, will be rescinded effective with this MEMTL. The new rule has format changes to make it consistent with other new rules in the Medicaid Eligibility Manual and clarifies the administrative agency's role in facilitating outreach services for pregnant women and children through the process of outstationing at disproportionate share hospitals and federally qualified health centers.

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MEMTL 26 (Budgeting Methodology For Individuals Under Age Twenty-One Not Living With A Parent Or Spouse)

Medicaid Eligibility Manual Transmittal Letter No. 26

November 30, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: budgeting methodology for individuals under age twenty-one not living with a parent or spouse.

The Ohio Department of Job and Family Services (ODJFS) reviewed this rule in accordance with section 119.032 of the Revised Code. This MEMTL contains one rule of the Administrative Code: 5101:1-40-25.1 "Medicaid: budgeting methodology for individuals under age twenty-one not living with a parent or spouse."

This new rule clarifies the budgeting methodology for individuals under the age of twenty-one not living with a parent or spouse. Individuals requesting Medicaid under this category must meet all eligibility criteria applicable to such individuals in chapters 5101:1-37 through 5101:1-42 of the Administrative Code.

The effective date of this MEMTL is: January 1, 2006.

Chapter 4
5101:1-40-25.1 Medicaid: budgeting methodology for individuals under age twenty-one not living with a parent or spouse.

Rule 5101:1-40-25.1 of the Administrative Code is a new rule that replaces rule 5101:1-40-251 of the Administrative Code. Rule 5101:1-40-251 will be rescinded effective with this MEMTL. The new rule has format changes to make it consistent with other new rules in the Medicaid Eligibility Manual and clarifies the category of "individuals under the age of twenty-one not living with a parent or spouse."

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MEMTL 24 (Coverage for an Individual Added to an Ongoing Case)

Medicaid Eligibility Manual Transmittal Letter No. 24

October 20, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Coverage for an individual added to an ongoing case

This MEMTL rescinds one rule of the Administrative Code: 5101:1-40-093 "Covered families and children medicaid: coverage for an individual added to an ongoing case."

The effective date of this MEMTL is: December 1, 2005

This rule has been reviewed in accordance with Section 119.032 of the Revised Code and is proposed for rescission. The content of this rule is duplicated within other existing Medicaid eligibility rules. The rescission of this rule does not impact an individual's eligibility for Medicaid.

Chapter 4
5101:1-40-093 Covered families and children Medicaid: coverage for an individual added to an ongoing case.

The content of this rule is duplicated within the following Medicaid eligibility rules:

- Determination of eligibility for Medicaid is addressed in rule 5101:1-38-01
- The beginning date of eligibility for an individual added to an existing assistance group is defined in rule 5101:1-38-01.4
- Assistance groups are defined in rule 5101:1-40-01
- Covered groups are defined in rule 5101:1-40-01.1
- Retroactive coverage is defined in rule 5101:1-38-01.3
- Reporting changes is addressed in rule 5101:1-38-02
- Pre-termination review of continuing Medicaid eligibility and prior notice requirements are defined in rule 5101:1-38-01.1 and division-level designation 5101:6 of the OAC
- Coverage for newborns is addressed in 5101:1-40-02.2.

Fiscal Impact

The rescission of this rule does not impose any new requirements on county agencies and therefore, the implementation of the rule change should result in no fiscal impact on the county agencies.

Training Statement

The rescission of this rule will not require training or technical assistance to be provided to county staff by ODJFS. Clarification regarding the rescinded rule will be available to county staff through the CFC Technical Assistance staff and the ABD Technical Assistance staff.

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MEMTL 23 (Healthchek and Pregnancy Related Services)

Medicaid Eligibility Manual Transmittal Letter No. 23
August 4, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: early and periodic screening, diagnosis and treatment (EPSDT) - "Healthchek"

Medicaid: pregnancy related services (PRS)

- This MEMTL contains two rules from Chapter 5101:1-38 of the Administrative Code.
- These amended rules clarify documentation requirements for the administrative agency concerning the management of the Healthchek and Pregnancy Related Services programs. The documentation that the state currently has on file (Program Implementation Plans or Letters) is obsolete and must be updated. This rule is necessary to meet compliance measures established by the federal Centers for Medicare and Medicaid Services (CMS) for monitoring and evaluation of these Medicaid programs.

Effective date: October 15, 2005

Chapter 5

Medicaid: early and periodic screening, diagnosis and treatment (EPSDT) - "Healthchek." OAC rule 5101:1-38-05

This rule is amended to include language that requires CDJFS agencies to submit in writing, under signature of the CDJFS director, a description of the process and structure of the management of the local Healthchek program including the name of the contact person and/or coordinator for the program.

Medicaid: pregnancy related services (PRS). OAC 5101:1-38-06

This rule is amended to include language that requires CDJFS agencies to submit in writing, under signature of the CDJFS director, a description of the process and structure of the management of the local pregnancy related services (PRS) program including the name of the contact person and/or coordinator for the program.

Submission of a Local Program Management Description (LPMD) for the HEALTHCHEK and Pregnancy Related Services (PRS) Programs

The Centers for Medicare and Medicaid Services (CMS) has recommended that the State of Ohio provide technical assistance as needed to all 88 counties to enhance the understanding of the Healthchek and PRS programs. In an effort to respond to this recommendation and effectively monitor these programs at the local level, ODJFS is requiring each county department of job and family services (CDJFS) to submit an updated LPMD for the Healthchek and PRS programs within their agencies. Requirements such as provision of beneficiary information and case management of support services will be reviewed.

Rules 5101:1-38-05 and 5101:1-38-06 pertaining to 'Documentation Requirements' for both programs are updated to reflect the need for each CDJFS to submit a LPMD for these programs. This will allow ODJFS to monitor each county based on the structure outlined within their LPMD.

The attached instructions for creating the LPMD and suggested templates are included as an attachment in this MEMTL to assist you in preparing the information that will be needed for the document.

If you have any questions, please contact the OHP County Compliance Section at (614) 728-8476 or submit inquiries through the Healthchek_PRS GroupWise mailbox. Please reference 'LPMD' in the subject line of the e-mail.

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MEMTL 22 (Eligibility Determinations and Patient Liability)

Medicaid Eligibility Manual Transmittal Letter No. 22

June 20, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid eligibility determinations and patient liability determinations for

- Individuals in institutions,
- Individuals receiving home and community-based services, and
- Individuals receiving services under the Program of All Inclusive Care for the Elderly (PACE)

This MEMTL contains fifteen rules from Chapter 5101:1-39 of the Administrative Code.

These new and amended rules clarify the process of determining eligibility using the special income level and determining patient liability for certain institutionalized individuals, individuals receiving services under the HCBS waiver program or PACE. The new rules are formatted consistent with other new rules in the Medicaid Eligibility Manual (MEM).

The most significant change occurs in new rule 5101:1-39-24, which adjusts the application of patient liability in partial months of institutionalization. Previously individuals were not held responsible for providing these payments in partial months of admission, discharge, or death. Due to federal clarification, we must now prorate the patient liability amount in these partial months. The rule explains the simple formula and requires that the administrative agency hold the individual responsible for this share of costs.

The effective date for all rules is July 1, 2005.

Chapter 3

The following rules are new:

5101:1-39-23 Medicaid: income computations for determining eligibility under covered groups using the special income level.

This rule is based on paragraph (A) of rescinded rule 5101:1-39-22.2 and paragraphs (A) through (F) of rescinded rule 5101:1-39-95. Portions of these two rescinded rules that address patient liability are also included in new rule 5101:1-39-24.

This new rule includes references to individuals receiving services under the HCBS waiver program or PACE.


This rule explains that when an individual is institutionalized for less than a full month, the administrative agency must prorate the amount of patient liability. This is explained in paragraph (C) (2) (i).

This new rule also includes references to individuals receiving services under the HCBS waiver program or PACE.

The following rules are amended:


This rule is amended to include language regarding the determination of QMB and SLMB eligibility, previously addressed in rescinded rule 5101:1-39-22.2. It also includes language regarding individuals receiving services under HCBS waiver program or PACE, removes references to the Qualified-Individual-2 (QI-2) group, and makes minor clarifications and grammatical corrections.
This rule is amended to include language regarding the treatment of resources in HCBS waiver cases, previously addressed in rescinded rule 5101:1-39-95 and to make minor clarifications and grammatical corrections.
This rule includes references to individuals receiving services under the HCBS waiver program or PACE.

This rule is amended to remove references to rescinded rule 5101:1-39-95, include a reference to amended rule 5101:1-39-35, and to make minor clarifications and grammatical corrections.
This rule includes references to individuals receiving services under the HCBS waiver program or PACE.

This new rule includes references to individuals receiving services under the HCBS waiver program or PACE.
The following rules are rescinded:
5101:1-39-85 Medicaid-eligible veterans and surviving spouses of certain veterans in long term care facilities with no community spouse and dependent family member(s).
5101:1-39-22.4 Medicaid: family allowance for dependents of institutionalized individuals and home and community-based services waiver (HCBS) individuals who do not have a community spouse.

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MEMTL 20 (In-Kind Support and Maintenance)
Medicaid Eligibility Manual Transmittal Letter No. 20
June 9, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: In-Kind Support and Maintenance

The rule contained in this MEMTL is 5101:1-39-17 of the Administrative Code, "Medicaid: in-kind support and maintenance."

This new rule replaces current rule 5101:1-39-17 of the Administrative Code, "Medicaid: In-Kind Support and Maintenance," effective January 1, 1999. This new rule clarifies how in-kind support and maintenance is valued for purposes of determining eligibility under the Medicaid aged, blind, or disabled covered groups. This new rule also has format changes to make it consistent with other new rules in the Medicaid Eligibility Manual (MEM).

The effective date of this MEMTL is July 1, 2005.

MEM Chapter 3

Key points of reissued rule 5101:1-39-17 of the Administrative Code include:

1. "In-kind support and maintenance" is unearned income in the form of food or shelter, or something that can be used to get food or shelter, that a person is given or receives because someone else pays for it.

2. In-kind support and maintenance received by an individual is exempt or disregarded if it is identified as exempt or disregarded in accordance with rule 5101:1-39-18 or rule 5101:1-39-26 of the Administrative Code, it is received from another member of a public assistance household, or if the individual receives SSI and the social security administration (SSA) does not reduce the individual's SSI benefit because of in-kind support and maintenance.

3. In-kind support and maintenance received by an individual is valued by applying the "household of another" Medicaid need standard, as set forth in Medicaid Eligibility Procedure Letter (MEPL) No. 1, when the individual is a recipient of SSI benefits and receives the one-third reduction in the SSI benefit or when the individual lives for an entire month in another person's household and receives both food and shelter for the entire month from someone living in that household.

4. In-kind support and maintenance received by an individual is valued by treating the in-kind support and maintenance as countable unearned income, using the presumed maximum value when the "household of another" Medicaid need standard, described in paragraph (D) of this rule, does not apply. The individual shall be provided the opportunity to demonstrate that the presumed maximum value shall not be used, in accordance with paragraph (F) of this rule.

5. In-kind support and maintenance received by an individual is valued by treating the in-kind support and maintenance as countable unearned income, using the current market value or actual value, whichever is less, when the individual demonstrates that the current market value of any in-kind support and maintenance received, minus any payment the individual makes for them, is less than the presumed maximum value; or the actual amount someone else pays for the individual's in-kind support and maintenance is less than the presumed maximum value.

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MEMTL 19 (JFS 07124 Eligibility Information Worksheet)

Medicaid Eligibility Manual Transmittal Letter No. 19

April 29, 2005

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: JFS 07124, "Eligibility Information Worksheet for Nursing Home and Home and Community Based Services (HCBS) Waivers"

The Office of Family Stability has obsoleted the JFS 07100, "Application for Income, Medicaid, and Food Assistance" and revised the JFS 07200, "Request for Cash, Food Stamp, and Medical Assistance". The information concerning the issuance of the revised application forms is contained in FSTL No. 262 and CAMTL No. 18.

The effective date of this MEMTL is May 1, 2005.

Administrative Agency Responsibilities:

1) The administrative agency shall determine medical assistance and Medicaid eligibility in accordance with the application processing rules contained in Chapter 5101:1-38 of the Administrative Code.

2) Effective May 1, 2005, the administrative agency shall no longer initiate the application process for medical assistance and Medicaid with the JFS 07100. However, if the applicant submits a JFS 07100 after May 1, 2005, the administrative agency shall accept it as an application for medical assistance and Medicaid and process it accordingly. The administrative agency shall document in the individual's case record that the JFS 07100 was received after May 1.

3) Effective May 1, 2005, the administrative agency shall initiate the application process with the revised JFS 07200, "Request for Cash, Food Stamp, and Medical Assistance" for individuals who are applying for medical assistance and Medicaid:
   1. Under the categories of "aged", "blind" or "disabled";
   2. For long-term care services (nursing home and HCBS Waivers); or
   3. In addition to other benefits such as Cash Assistance or Food Stamps.

4) The administrative agency shall utilize the following forms in the same manner as utilized prior to May 1, 2005:
   1. JFS 07216, "Healthy Start/Healthy Families Combined Programs Application";
   2. JFS 07237, "Healthy Start/Healthy Families Combined Programs Application" in Spanish;
   3. JFS 07103, "Application for Help with Medicare Expenses";
   4. JFS 07103S, "Application for Help with Medicare Expenses" in Spanish;
   5. JFS 07161, "Ohio Breast and Cervical Cancer Project (BCCP) Medicaid Application"
   6. JFS 07161S, "Ohio Breast and Cervical Cancer Project (BCCP) Medicaid Application" in Spanish; and
   7. JFS 01137, "Child Care/Healthy Start and Healthy Families Supplement".

Appendix

JFS Forms

Eligibility Information Worksheet for Nursing Home and Home and Community Based Services (HCBS) Waivers - JFS 07124
This is a new form that replaces the JFS 07100, "Application for Income, Medicaid, and Food Assistance". It shall be used by the administrative agency to collect information to determine Medicaid eligibility for individuals applying for Medicaid long-term care services (nursing homes and HCBS Waivers). It is intended to supplement the information collected on the revised JFS 07200. It shall not replace the revised JFS 07200.

The JFS 07124 shall be completed by the administrative agency eligibility worker during an off-site interview or when CRISE is unavailable. The Medicaid applicant shall not complete the JFS 07124, but shall sign where indicated on the last page after the eligibility worker has completed it.

The JFS 07124 will be available for ordering from the ODJFS warehouse services unit.

The tables below clarify when the applicant is required to sign the JFS 07200, JFS 07124 and PCI*.

**Applicant signature during initial application for medical assistance**

<table>
<thead>
<tr>
<th></th>
<th>Face-to-face interview at administrative agency</th>
<th>Face-to-face interview off-site</th>
<th>Telephone interview</th>
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<td>JFS 07200 and the PCI*</td>
<td>JFS 07200 and the JFS 07124</td>
<td>JFS 07200 and the PCI (mail to applicant)</td>
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<td>JFS 07200 and the JFS 07124</td>
<td>JFS 07200 and the JFS 07124</td>
<td>JFS 07200 and the PCI (once CRISE becomes available, mail to applicant)</td>
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*PCI is the CRISE generated "printed copy of the information" as specified in rule 5101:1-38-01.2 of the Administrative Code.

**Applicant signature during the redetermination process for medical assistance**

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<td>Appendix JFS Forms</td>
<td>JFS 07100 (revised 4/2001)</td>
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This information is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**

http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

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MEMTL 18 (Medicaid: Hospice)

Medicaid Eligibility Manual Transmittal Letter No. 18
April 1, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Hospice

The rule contained in this MEMTL is 5101:1-39-83 of the Administrative Code, "Medicaid Hospice".
The effective date of this MEMTL is April 1, 2005.

Chapter 3

5101:1-39-83 of the Administrative Code, Medicaid Hospice

5101:1-39-83 of the Administrative Code, "Medicaid Hospice." The content of this rule is duplicated within the hospice program rules. Subsequently, the rule is to be rescinded. Hospice is a service provided to individuals with Medicaid eligibility. The implementation of this service is addressed in rule 5101:3-56-02 of the Administrative Code. The hospice program and services is outlined in Chapter 5101:3-56 of the Administrative Code.

The rescission of rule 5101:1-39-83 removes the restriction on Home and Community Based Services (HCBS) waivers and hospice enrollment. Rule 5101:3-56-02 has been amended to reference eligibility rules and allows HCBS waiver enrollees to elect the hospice benefit.

The budgeting method shall be applied as institutional or non-institutional as appropriate. Non-institutional budgeting methodology shall be applied to those individuals that live within the community or a free standing hospice location. For an individual that resides in a Long Term Care Facility or receives waiver services, the institutionalized budget methodology shall be used for determination of eligibility.

Statement of Fiscal Impact on County Agencies - The rescission of the rule does not impose any new requirements on county agencies and therefore, the implementation of this rule change should result in no fiscal impact on the county agencies.

Statement of Training and Technical Assistance for County Agencies - The rescission of the rule will not require training or technical assistance to be provided to county staff by ODJFS. Questions regarding Hospice services should be directed to the Bureau of Health Plan Policy.

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MEMTL 17 (Rescission of Medicaid Rules related to Direct Bill)

Medicaid Eligibility Manual Transmittal Letter No. 17

January 11, 2005

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Medicaid: Rescission of Medicaid Rules related to Direct Bill

- This MEMTL will rescind two rules:
  - 5101:1-39-12.1 of the Administrative Code, "Billing process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)."

- The effective date of this MEMTL is January 6, 2005

Chapter 3

5101:1-39-12.1 of the Administrative Code, "Billing process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)." This rule is rescinded. Utilization of the payment and adjustment process is addressed in Chapter 5101:3-3 of the Administrative Code.

5101:1-39-12.2 of the Administrative Code, "Medicaid: information sharing with long term care facility (LTCF) providers." This rule is rescinded. The administrative agency's responsibility to use the JFS 09401 to communicate patient liability and/or vendor payment changes to the LTCF is included in rule 5101:3-3-39 of the Administrative Code.

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MEMTL 16 (Limiting Physical Factor and Four-Month Extended Coverage)

Medicaid Eligibility Manual Transmittal Letter No. 16

December 15, 2004

To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Limiting Physical Factor and Four-Month Extended Coverage

- Rule 5101:1-40-05.1 of the Administrative Code is revised for clarity and will replace rule 5101:1-40-05.9 of the Administrative Code.
- Rule 5101:1-40-21 is rescinded with the issuance of this MEMTL. This rule is not contained in the Medicaid Eligibility Manual, however, due to an administrative error it remained in effect in Administrative Code.
- The effective date of this MEMTL is January 1, 2005.

Chapter 3

Medicaid: Limiting Physical Factor - 5101:1-39-03


NOTE: The issuance of 5101:1-39-03 reflects significant policy changes.

1) The administrative agency will make the determination of limiting physical factor without sending a CMS packet to the CMS unit in only three circumstances:
   - When the individual is age 65 or older;
   - When the individual is approved for SSA disability benefits for the individual's own disability or blindness; or
   - When an individual has a level of care (LOC) determination in accordance with rule 5101:1-39-04 of the Administrative Code.

In all other circumstances, the administrative agency must submit a CMS packet to the CMS Unit for a disability determination.

1) Language was added to clarify that as a condition of Medicaid eligibility, the administrative agency must refer individuals to the Social Security Administration (SSA) to apply for any SSA disability benefits that they may be entitled to receive.

2) Language was added to reinforce that when necessary, the administrative agency must utilize administrative funds to assist an individual in building a case to support their disability claim.

3) Language was added to describe the CMS Unit Continuing Disability Review (CDR) process and the requirements of the administrative agency.

4) The new rule reflects the Federal changes for presumptive disability impairments and conditions.

5) Clarification was added regarding an individual's Medicaid eligibility during an initial eligibility determination and continuing disability review (CDR).

6) Clarification was added regarding an individual's Medicaid eligibility when an individual reapplies for Medicaid (after termination), when a disability determination is still in effect.
Chapter 4

Medicaid: Four-Month Extended Coverage - 5101:1-40-05.1

Rule 5101:1-40-05.1 of the Administrative Code is a new rule that replaces rule 5101:1-40-05.9 of the Administrative Code. The new rule has format changes to make it consistent with other new rules in the Medicaid Eligibility Manual (MEM).

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MEMTL 15 (Income Computations for Medicaid Healthy Start)

Medicaid Eligibility Manual Transmittal Letter No. 15

December 2, 2004

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Medicaid: Income Computations for Determining Eligibility Under the Medicaid Healthy Start Covered Group

- The rule contained in this MEMTL is 5101:1-40-08.1 of the Administrative Code, "Medicaid: income computations for determining eligibility under the medicaid healthy start covered group."

- This new rule replaces current rule 5101:1-40-08.1 of the Administrative Code, "Healthy start: budgeting method." This new rule clarifies the procedure for income computations for determining eligibility under the Medicaid Healthy Start covered group. This new rule also has format changes to make it consistent with other new rules in the Medicaid Eligibility Manual (MEM).

- The effective date of this MEMTL is January 1, 2005. If there are changes made to the rule contained in this MEMTL during the JCARR review period, a corrected rule will be released in a subsequent MEMTL.

**MEM Chapter 4**

5101:1-40-08.1 of the Administrative Code, "Medicaid: Income computations for determining eligibility under the medicaid healthy start covered group."

Key points of reissued rule 5101:1-40-08.1 of the Administrative Code include:

- "Assistance group" is defined in accordance with rule 5101:1-38-01.2 of the Administrative Code.

- Countable income is determined by totaling all gross income, earned and unearned, of the assistance group, excluding all appropriate income exemptions, and subtracting all appropriate income disregards.

- The assistance group meets the healthy start income criterion if the assistance group's countable income is equal to or less than the appropriate healthy start standard, as stated in rule 5101:1-40-26 of the Administrative Code.

- The assistance group does not meet the healthy start income criterion if the assistance group's countable income is greater than the appropriate healthy start standard, as stated in rule 5101:1-40-26 of the Administrative Code.

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MEMTL 14 (Alien Emergency Medical Assistance (AEMA))

Medicaid Eligibility Manual Transmittal Letter No. 14

November 23, 2004

To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Alien Emergency Medical Assistance (AEMA)

- The effective date of this MEMTL is December 1, 2004. If there are changes made to the rules contained in this MEMTL during the JCARR review period, a corrected rule will be released in a subsequent MEMTL.

Chapter 5

Medicaid: Alien Emergency Medical Assistance - 5101:1-41-20

Rule 5101:1-41-20 of the Administrative Code is a new rule. It replaces rule 5101:1-42-02 of the Administrative Code. The rule format was revised to be consistent with other new rules in the Medicaid Eligibility Manual (MEM). Other revisions include:

1) An added definition of "administrative agency".
2) A new group of individuals are eligible for AEMA: "Optional Qualified Aliens". This group is defined in paragraph (B).
3) A more specific definition of "emergency medical condition episode".
4) Revised eligibility requirements in paragraph (C).
5) Revised eligibility criteria exceptions in paragraph (D). Qualified aliens are no longer required to provide a social security number or have their immigrant/alien status verified. In addition, an exception is added for a face-to-face interview.
6) A significant revision is made in paragraph (E)(4) concerning the eligibility span for labor and delivery:
   - The administrative agency may approve an eligibility span for a labor and delivery episode for up to a maximum of 48 hours following a vaginal delivery and up to a maximum of 96 hours following a caesarian section delivery. In addition to the time span following delivery, the administrative agency may approve up to a maximum of 48 hours for labor. This provides a combined maximum eligibility span for the labor and delivery episode of 96 hours (4 days) for a vaginal delivery and 144 hours (6 days) for a caesarian section delivery.

Background:

The intent of Alien Emergency Medical Assistance is to provide retrospective eligibility for the individual and payment to the Medicaid provider. Therefore, it is not appropriate to:

1. Open an eligibility span for an individual prior to the beginning date of the emergency medical condition episode;
2. Open a "standard" timeframe or one-month eligibility span for an emergency medical condition episode; or
3. As a standard, open an eligibility span for labor and delivery that is the maximum timeframes allowed in the rule, (i.e., do not routinely open a 4-or 6-day eligibility span for labor and delivery because these are the maximum timeframes.)
The administrative agency must enter an eligibility span into CRISE that is date-specific and within the covered dates of service that are specified by the CMS Unit. For labor and delivery, the administrative agency must enter an eligibility span into CRISE that is date-specific and up to the maximum timeframes as outlined in paragraph (E) of rule 5101:1-41-20.

The appropriate procedure for determining AEMA eligibility spans:

1. The administrative agency shall send the AEMA case to the CMS Unit for the determination of the covered dates of service (except for labor and delivery, as outlined in paragraph (E) of rule 5101:1-41-20); and
2. The administrative agency must FIAT the individual’s eligibility in CRISE and open an eligibility span within the covered dates of service as specified by the CMS Unit or as outlined in paragraph (E) of rule 5101:1-41-20 for labor and delivery.

For AEMA labor and delivery cases that are pending with the CMS Unit as of December 1, 2004:

Administrative Agency responsibilities:

- Effective December 1, 2004, the administrative agency must apply the timeframes for labor and delivery as outlined in paragraph (E)(4) of rule 5101:1-41-20 to all AEMA labor and delivery cases (new and pending with the CMS Unit).
- If the administrative agency has or is able to obtain the information necessary to apply the new timeframes for the AEMA labor and delivery cases that are pending with the CMS Unit, the administrative agency shall apply the revised timeframes to those cases.
  1) If the labor and delivery episode is within the timeframes as outlined in paragraph (E)(4), the administrative agency shall enter the appropriate eligibility span into CRISE. All cases that are outside the timeframes specified in paragraph (E)(4) of the rule shall remain with the CMS Unit for a determination of covered dates of service.
  2) The administrative agency shall then notify the CMS Unit to specify which cases no longer require a determination of covered dates of service.
- If the administrative agency does not have or is unable to obtain the information necessary to apply the new timeframes for the AEMA labor and delivery cases that are pending with the CMS Unit, the cases shall remain with the CMS Unit for a determination of covered dates of service.
  1) The administrative agency shall then notify the CMS Unit to specify that all cases require a determination of covered dates of service.

CMS Unit responsibilities:

- Upon notification from an administrative agency about the cases that no longer require a determination of covered dates of service, the CMS Unit shall return the cases to the appropriate county.
- The CMS Unit shall determine the covered dates of service to all cases that remain at the CMS Unit and shall apply the new timeframes as specified in paragraph (E)(4) of the rule.

Appendix

MEM Desk Aids

AEMA Desk Aid for 5101:1-41-20

An AEMA desk aid has been developed in a flowchart format to better assist administrative agencies in processing AEMA eligibility. It will be posted in the MEM Desk Aids section of the Medicaid Eligibility Manual on 1/1/2005.

MEM Instructions:
This information is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/ohpelegibility/MEM

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Medicaid Eligibility Manual Transmittal Letter No. 13

October 21, 2004

To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Retirement and Income Supplementing Accounts (RISAs)

• The rule contained in this MEMTL is 5101:1-39-22.7 of the Administrative Code, "Medicaid: Retirement and Income Supplementing Accounts (RISAs)."

• This new rule replaces current rule 5101:1-39-22.7 of the Administrative Code, "Retirement funds." This new rule clarifies how retirement and income supplementing accounts (RISAs) are treated for the purposes of determining medicaid eligibility and clarifies when a RISA is treated as a resource and when a RISA is treated as income. This new rule also has format changes to make it consistent with other new rules in the Medicaid Eligibility Manual (MEM).

• The effective date of this MEMTL is December 1, 2004.

MEM Chapter 3
5101:1-39-22.7 of the Administrative Code, "Medicaid: Retirement and Income Supplementing Accounts (RISAs)."

Key points of reissued rule 5101:1-39-22.7 of the Administrative Code include:

• Retirement and income supplementing accounts (RISAs) are plans designed to provide unearned income to supplant or supplement earned income.

• A RISA is a countable resource if the individual or the community spouse has an ownership interest in the RISA and the legal ability to convert it to cash.

• If there is a financial penalty imposed by the plan administrator in order to convert the account to cash, the amount of the countable resource is the net amount payable to the individual after deducting the penalty. The amount payable may not be further reduced by the amount of any tax incurred by the individual as a result of the conversion of the account to cash.

• If the RISA is determined to be a non-countable resource, then the RISA shall be evaluated as a potential source of unearned income.

• A RISA in which an individual has the legal ability to receive regular guaranteed lifetime payments shall be treated as a source of unearned income rather than as a resource.

• The individual is required to obtain the maximum available amount of payment from the plan. If the maximum available amount of payment requires the individual's spouse to consent to a waiver of the spouse's survivor benefits, the individual must document a good faith attempt to obtain that consent, and whether consent was obtained or refused. If consent is not obtained, the individual must elect the minimum spousal survivor benefit required by the plan.

• If allowed in the plan, the individual may elect a lesser payment in favor of retaining a minimum survivor benefit for a child who can be documented to be blind or disabled, as defined in rule 5101:1-39-03 of the Administrative Code.

• The administrative agency shall obtain the summary plan description or other document describing the rights and benefits under the RISA.

• As a condition of medicaid eligibility, the administrative agency shall require applicants and recipients to take all necessary steps to obtain any pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.
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MEMTL 12 (Processing Requests for HCBS)

Medicaid Eligibility Manual Transmittal Letter No. 12

August 5, 2004

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Home and Community-Based Services (HCBS) Waiver Programs

- This new rule clarifies the procedure for processing requests for Medicaid coverage of home and community-based services. Individuals requesting Medicaid coverage of home and community-based services must meet all eligibility criteria applicable to such individuals in chapters 5101:1-37 through 5101:1-42 of the Administrative Code.


- "Home and Community-Based Services Waiver Referral,” JFS 02399 has been revised and renamed "Request for Medicaid Home and Community-Based Services (HCBS),” (JFS 02399). The revised form includes updated information and conforms with ODJFS formatting requirements.

- The effective date of this MEMTL is October 1, 2004. If there are changes made to the rules contained in this MEMTL during the JCARR review period, a corrected rule will be released in a subsequent MEMTL.

Background:

Home and community-based services (HCBS) are services that provide certain Medicaid recipients an alternative to placement in a hospital, a nursing facility (NF), or an intermediate care facility for persons with mental retardation (ICF/MR). HCBS are approved by the federal Centers for Medicare and Medicaid Services (CMS) and are not otherwise available under the Medicaid state plan.

Medicaid HCBS waiver programs waive certain Medicaid statutory requirements, such as allowing HCBS:

- To be provided in limited areas of the state
- To be provided to certain individuals rather than all Medicaid recipients.

MEM Chapter 2

"Medicaid: Processing requests for home and community-based services (HCBS)” (rule 5101:1-38-01.6 of the Administrative Code)

Key points of new rule 5101:1-38-01.6 of the Administrative Code include:

- Medicaid coverage of HCBS cannot precede the date the administrative agency receives a "Request for Medicaid Home and Community-Based Services," JFS 02399, signed by the individual, or, if the administrative agency receives a signed and dated JFS 02399 within five working days from the date of signature on the JFS 02399 from an HCBS waiver agency, the administrative agency must accept the signature date as the date of request. When the administrative agency receives a JFS 02399 after the fifth working day, the request date must be the date the administrative agency receives the JFS 02399. This is a change in language from paragraph (A) of rescinded rule 5101:1-39-94 of the Administrative Code, "Medicaid: HCBS waiver application/enrollment process,” which protected a JFS 02399 signature date only when the JFS 02399 was returned for completion of a JFS 07100. This is also a change in language from paragraph (J) of the same rule, which provided no timelines for
waiver agencies to notify administrative agencies of an individual's interest in Medicaid coverage of HCBS. Inclusion of this new language protects, within limits, the date on which the consumer signs the JFS 02399. This language is consistent with paragraph (H)(4) of rule 5101:1:38-01.2 of the Administrative Code, describing the timelines for honoring the signature date on the Combined Program Application (JFS 07216) from BMCH, CFHS and WIC agencies.

- Individuals who request Medicaid coverage of HCBS but who have either not applied for Medicaid or applied for Medicaid previously but have been denied, must apply for Medicaid. This language is included to clarify that HCBS are services available only to certain Medicaid recipients and that determination of medical assistance eligibility must be made in accordance with Chapters 5101:1-37 to 5101:1-42 of the Administrative Code.

- The JFS 02399 is a request for Medicaid coverage of home and community-based services, and should not be confused with an application for Medicaid (i.e., JFS 7100 or JFS 7200). An individual interested in receiving HCBS must apply for Medicaid and request HCBS.

- The administrative agency must, on the day of its receipt of a JFS 02399 from an individual who is neither currently in receipt of Medicaid nor with a Medicaid application pending, give or mail to the individual a JFS 07100 or a JFS 07200. Submission of a JFS 07100 or JFS 07200 is only necessary for individuals who are neither currently in receipt of Medicaid nor with a Medicaid application pending.

- The administrative agency must coordinate processing requests for Medicaid coverage of HCBS with HCBS waiver agencies. This language is included to clarify that approval of Medicaid coverage of HCBS requires approval by two entities: the administrative agency (CDJFS) and the HCBS waiver agency.

- The administrative agency must, within five days of the receipt of a signed JFS 02399, notify the applicable HCBS waiver agency, via the electronic eligibility system, of the receipt of the JFS 02399 and the JFS 07100 or the JFS 07200. If the HCBS waiver agency is not known or if multiple waiver agencies are indicated on the JFS 02399, the administrative agency must submit the JFS 02399 to the ODJFS, bureau of home and community services.

- When an individual is approved for Medicaid coverage of HCBS for a portion of a month, that individual is eligible for Medicaid for the entire month, in accordance with rule 5101:1-38-01.4 of the Administrative Code. This language is included to clarify that individuals who have been approved for Medicaid coverage of HCBS must have the beginning date of Medicaid as the first day of the month of application, even if the first day of Medicaid coverage of HCBS begins after the first of the month of application.

- The administrative agency (CDJFS) must provide written notification to the individual who submits a JFS 07100 or JFS 07200 of the determination of medical assistance eligibility and the amount of patient liability, if any. HCBS waiver agencies must provide written notification of determinations to individuals, including to whom any patient liability must be paid. This language is included to reflect a change in notice responsibilities. CRIS-E notices will change accordingly.

- If HCBS are terminated, Medicaid eligibility for the individual must continue, in accordance with rule 5101:1-38-01.1 of the Administrative Code. This language is included to clarify the administrative agency's obligation to conduct pre-termination reviews in accordance with rule 5101:1-38-01.1 of the Administrative Code.

- References to detailed processes of the electronic eligibility system (CRIS-E) are not included in new rule 5101:1-38-01.6 of the Administrative Code. Users of the electronic eligibility system should reference the CRIS-E Users Manual for detailed information on using CRIS-E.

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**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEMTL 11 (Revised and Translated Forms)
Medicaid Eligibility Manual Transmittal Letter 11
April 23, 2004

To: Directors, County Departments of Job and Family Services
From: Thomas J. Hayes, Director
Subject: Medicaid: Revised and Translated Forms

This Medicaid Eligibility Manual Transmittal Letter introduces the revised Combined Programs Application (CPA) in English and Spanish languages and the Spanish translation of a number of ODJFS forms.

JFS Forms (CCN 4970)
The CPA, JFS 07216 and JFS 07237, has been revised to reflect the following changes:

- All references to the annual premium have been removed.
- Language has been included to inform consumers of their obligation to participate in establishing medical support for their children.
- Language regarding child support payments has been removed. Child support paid is not counted as monthly income for Healthy Start and Healthy Families but is counted for the nutritional program for Women, Infants and Children (WIC).
- Information on race and ethnicity are now separate questions.

Counties may exhaust their current supply of the JFS 7216 (5/2000) or access the online application for immediate use. When ordering the JFS 7216 through the warehouse, all current supplies will be exhausted prior to sending out the new form.

The following forms are now also available in Spanish.

JFS 03531 Evaluación de los Servicios Healthchek y de Embarazo
JFS 03531 Instrucciones Para El Uso Del Formulario De Evaluación Para Los Servicios HealthchekY De Embarazo
JFS 07103 Application for Help with Medicare Expenses
- JFS 07103S Solicitud Para Recibir Ayuda Con Los Gastos De Medicare
JFS 07161 Ohio Breast and Cervical Cancer - Medicaid Application
- JFS 07161S Proyecto de Cáncer Cervical y de Seno del Estado de Ohio ("BCCP") Solicitud de Medicaid
JFS 07212 Explanation of Qualified Medicare Beneficiary - QMB - Medicaid Coverage
- JFS 07212S Explicación de "Beneficiario Calificado de Medicare" ("QMB"), por sus siglas en inglés) Cobertura de Medicaid
JFS 07237 Healthy Start/Healthy Families (Comienzo Saludable y Familias Sanas) (Spanish CPA)
JFS 07400 Ohio Medicaid Estate Recovery
- JFS 07400S Recuperación Del Patarimonio Hereditario Por Parte Medicaid Del Estado De Ohio

This information is also available on the Internet and may be accessed at:
The ODJFS Electronic Manuals (previously known as dynaweb) has moved. Please update your Bookmarks/Favorites in your Internet browser:
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.
MEMTL 9A (correction to AEMA)

Medicaid Eligibility Manual Transmittal Letter No. 9A

October 24, 2003

To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Correction to Alien Emergency Medical Assistance (AEMA)

- The rule contained in this MEMTL is Medicaid: Alien Emergency Medical Assistance (AEMA) 5101:1-42-02.
- This rule was amended to add clarifying language regarding AEMA eligibility.
- The effective date of this MEMTL is December 1, 2003.
- If there are changes made to the rule contained in this MEMTL during the JCARR review period, a corrected rule will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/oheligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the Internet at:
http://www.odjfs.state.oh.us/lpc/calendar/index.asp

The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 5

Medicaid: Alien Emergency Medical Assistance (AEMA) - 5101:1-42-02

Language was added in paragraph (D)(2) to clarify that an individual is not required to apply for SSA program benefits as a condition of AEMA eligibility.

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MEMTL 10 (ADC- Medicaid Strikers and Medicaid Real Property)

Medicaid Eligibility Manual Transmittal Letter No. 10

October 16, 2003

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Medicaid: ADC Related - Strikers and The home and other real property as resources

With the de-linking of medicaid from other public assistance programs, the requirements of rule 5101:1-40-20.6 of the Administrative Code no longer apply to the medicaid program. Although rule 5101:1-39-31 of the Administrative Code is not in the Medicaid Eligibility Manual, due to administrative error, it remained in effect in Administrative Code. Both rules are rescinded effective October 14, 2003. If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL. These rules were waived from the clearance process.

This MEMTL is available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the Internet at: http://www.odjfs.state.oh.us/lpc/calendar/index.asp The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 4 Covered Families and Children (CFC)

Rule 5101:1-40-20.6: "ADC-related medicaid: strikers." This rule has been reviewed in accordance with Substitute House Bill 473, requiring the review of all state agency rules within a five-year period.

Rule 5101:1-39-31: "Medicaid: the home and other real property as resources." This rule has been reviewed in accordance with Substitute House Bill 473, requiring the review of all state agency rules within a five-year period.

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MEMTL 9 (AEMA)

Medicaid Eligibility Manual Transmittal Letter No. 9

September 16, 2003

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Medicaid: Alien Emergency Medical Assistance (AEMA)

- The rule contained in this MEMTL is Medicaid: Alien Emergency Medical Assistance (AEMA) 5101:1-42-02.
- Alien Emergency Medical Assistance (AEMA) is a new rule which replaces rule 5101:1-39-80 of the Administrative Code. The AEMA rule is in a new rule format to make it consistent with other new rules in the Medicaid Eligibility Manual (MEM). The Alien Emergency Medical Assistance policy was modified to be compliant with federal regulations.
- The effective date of this MEMTL is December 1, 2003.
- If there are changes made to the rule contained in this MEMTL during the JCARR review period, a corrected rule will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/). The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 5

Medicaid: Alien Emergency Medical Assistance (AEMA) - 5101:1-42-02


NOTE: The issuance of 5101:1-42-02 reflects two significant policy changes:

1. The administrative agency will no longer waive the twelve-month disability requirement as a part of the eligibility process for AEMA applicants. To qualify for AEMA, the individual must be otherwise eligible for a category of Medicaid, except for citizenship and the other requirements listed in paragraphs (C) and (D) of the rule; and

2. The administrative agency will be approving AEMA only for cases involving labor and delivery, up to a maximum of 2 days. The administrative agency will no longer be approving AEMA for any other emergency medical condition.

Administrative agency responsibilities:

1. The administrative agency must explore all categories of medicaid and determine the category or categories of Medicaid the AEMA applicant would be eligible for if the individual met the citizenship requirements.
   - If the only category of potential eligibility is the disability category of Medicaid, the administrative agency must follow the current process for a disability determination, as outlined in rule 5101:1-39-03 of the Administrative Code. However, the covered dates of service for this individual will be only for the duration of the emergency medical condition episode, and will be determined by the CMS unit. The administrative agency must enter the eligibility span, based on the covered dates of service determined by the CMS unit, into CRIS-E.

2. The administrative agency must determine if the individual is a resident of Ohio.
3. The administrative agency must determine if the individual meets the definition of "alien".

4. The administrative agency will no longer be required to determine whether an individual received treatment for an emergency medical condition, with the exception of labor and delivery.
   - For labor and delivery, the administrative agency must determine AEMA eligibility and the eligibility span, up to a maximum of 2 days. The administrative agency must enter the eligibility span into CRIS-E. If the labor and delivery episode is more than 2 days, the administrative agency must forward the medical documentation to the CMS unit and they will determine the covered dates of service.

5. If assistance is requested, the administrative agency must help the individual obtain medical documentation to support the emergent nature of the AEMA claim by requesting physician progress notes, discharge summary and supporting documentation from the medical provider. The administrative agency must then forward this documentation to the CMS unit.

6. The administrative agency must enter the eligibility span within the covered dates of service as determined by the CMS unit, into CRIS-E.

County Medical Services (CMS) responsibilities:

1. CMS will determine if an individual received treatment for an emergency medical condition.
2. CMS will determine covered dates of service for the emergency medical condition episode, except for labor and delivery when the labor and delivery episode is 2 days or less. CMS will determine covered dates of service for labor and delivery when the episode is more than 2 days.
3. CMS will notify the administrative agency of the AEMA determination and the covered dates of service via CRIS-E.

Appendix

JFS Forms

Alien Emergency Medical Assistance Medical Certification Form - JFS 07374

This form is obsolete along with the rescinding of rule 5101:1-39-80.

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MEMTL 8A (Correction to DMA)

Medicaid Eligibility Manual Transmittal Letter No. 8A

September 4, 2003

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Correction to Disability Medical Assistance (DMA) Program

- The rule contained in this MEMTL is Disability Medical Assistance (DMA) Program - 5101:1-42-01.
- The effective date of this MEMTL is September 5, 2003.
- Effective July 1, 2003, an Administrative Order to suspend the approval of applications for DMA is issued. Instructions for the Administrative Order are contained within Medicaid Information Letter (MIL) 03-009.

If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/ The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 5

Disability Medical Assistance (DMA) Program - 5101:1-42-01

Language is added to paragraph (F)(10) of the rule regarding conducting a pre-termination review (PTR) for other categories of medical assistance for DMA cases. Language is added to paragraph (F)(1) regarding giving the assistance group the opportunity to establish "medication dependency" at the next redetermination. The CDJFS must explore eligibility for all other categories of Medicaid prior to terminating a DMA case. Additionally, existing cases may not be terminated at redetermination until the assistance group has been given the opportunity to establish medication dependency.

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MEMTL 8 (DMA)

Medicaid Eligibility Manual Transmittal Letter No. 8

July 1, 2003

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Medicaid: Disability Medical Assistance (DMA)

- Amended Substitute House Bill 95 of the 125th General Assembly establishes significant changes to the existing state Disability Assistance (DA) program. One of the changes is that the DA program will be separated into two programs: The Disability Medical Assistance (DMA) program and the Disability Financial Assistance (DFA) program. The Disability Medical Assistance (DMA) program will be administered through the Office of Ohio Health Plans. The Disability Financial Assistance (DFA) program will be administered through the Office of Family Stability.

- The effective date of this MEMTL is July 1, 2003.

- Effective July 1, 2003, an Administrative Order to suspend the approval of applications for DMA is issued. Instructions for the Administrative Order are contained within Medicaid Information Letter (MIL) 03-009.

- If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/ The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 5

Disability Medical Assistance (DMA) Program - 5101:1-42-01

Eligibility Changes:

- For individuals who are eligible for the DA-medical program as of June 30, 2003, the CDJFS at the next redetermination, must use the DMA eligibility criteria outlined in paragraph (C) of this rule.

- For all DA-medical applications received before July 1, 2003, the CDJFS must use the DA-medical rules that were in effect before July 1, 2003. At the first redetermination of the assistance group's eligibility, the CDJFS must use the DMA rules that are in effect July 1, 2003.

- For all applications received on or after July 1, 2003, the CDJFS must use the eligibility criteria outlined in paragraph (C) of this rule.

Important change: Eligibility criteria to qualify for DMA will no longer include receipt of Disability Assistance cash. In order to qualify for DMA an individual must meet the definition of "medication dependency", as defined in paragraph (B) of this rule, plus all other eligibility criteria outlined in paragraph (C) of this rule.

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MEMTL 7 (Resource Budgeting for a Spouse in the Community)

Medicaid Eligibility Manual Transmittal Letter No. 7

July 1, 2003

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Medicaid: Resource Budgeting Method for Institutionalized Individuals With a Spouse in the Community.

- This rule is changed to comply with federal requirements. This rule clarifies that countable resources of the institutionalized spouse are to be used for the benefit of the institutionalized spouse and/or community spouse. This rule also relays when and how rights to support from the community spouse must be assigned to the state. The effective date of this MEMTL is July 1, 2003.

- If there are changes made to the rule contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpelegibility/MEMTL. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at:
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Chapter 3

Medicaid: Resource Budgeting Method for Institutionalized Individuals with a Spouse in the Community, OAC rule 5101:1-39-36.1"

- This rule is amended to comply with federal requirements:

- Paragraphs (A)(4) and (A)(5) are changed to state that the countable resources of the institutionalized spouse are to be used for the benefit of the institutionalized spouse and/or community spouse;

- Paragraphs (C)(1)(c) and (D)(1) are changed to state that when the institutionalized spouse has resources in excess of the individual resource limit, the institutionalized spouse will be eligible for Medicaid if certain conditions are met, including that rights to support from the community spouse have been assigned to the state. In addition, if the institutionalized spouse can not execute an assignment due to a physical or mental impairment, the state will bring a support proceeding against the community spouse.

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MEMTL 6A (Correction to HIPAA)

Medicaid Eligibility Manual Transmittal Letter No. 6A

September 8, 2003

To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Correction to Medicaid: Changes to rules related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- MEMTL No. 6A is issued for rules contained in MEMTL No. 6 which have minor revisions. The rules contained in this MEMTL are:
  - Medicaid: Income and Eligibility Verification System (IEVS) - 5101:1-37-03.1
  - Medicaid: Health Insurance Portability and Accountability Act (HIPAA) - 5101:1-38-01.5
  - Medicaid: Verification and Reporting Requirements - 5101:1-38-02
  - Medicaid: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - "Healthchek" - 5101:1-38-05
  - Medicaid: Pregnancy Related Services (PRS) - 5101:1-38-06
- The effective date is October 6, 2003.

If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/. The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 1

**Medicaid: Income and Eligibility Verification System (IEVS) - 5101:1-37-03.1**

The rule language was changed in paragraph (H)(3) to better reflect HIPAA regulations. Additional minor edits were made for clarity.

Chapter 2

**Medicaid: Health Insurance Portability and Accountability Act (HIPAA) - 5101:1-38-01.5**

The rule language on "Medical assistance program recipient's rights" was changed to "Administrative agency responsibilities", to remain consistent with new Medicaid rules format. Additional minor edits were made for clarity.

**Medicaid: Verification and Reporting Requirements - 5101:1-38-02**

The rule language was changed in paragraph (B)(8)(c) to better reflect HIPAA regulations. Additional minor edits were made for clarity.

Chapter 5

**Medicaid: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - "Healthchek" - 5101:1-38-05**

There is a minor edit in paragraph (F)(13), changing the word "release" to "authorization".

**Medicaid: Pregnancy Related Services (PRS) - 5101:1-38-06**
There is a minor edit in paragraph (D)(6)(g), changing the word "release" to "authorization".

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MEMTL 6 (HIPAA)

Medicaid Eligibility Manual Transmittal Letter No. 6

June 19, 2003

To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Changes to rules related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule implementation date was April 14, 2003. Medicaid and other medical assistance programs are subject to the new HIPAA privacy regulations. This MTL contains Medicaid eligibility rules and forms which were affected by the Privacy Rule implementation.

- The effective date of this MEMTL is September 1, 2003.

- This MTL contains rules and forms which were modified to be in compliance with HIPAA privacy regulations effective April 14, 2003. The majority of the changes include language which references rule 5101:1-37-01.1, Medicaid: Disclosure of Recipient Information and Confidentiality, and format changes to make them consistent with other rules contained in the Medicaid Eligibility Manual (MEM).

If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at: http://dynaweb.odfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/ The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 1

**Medicaid: Income and Eligibility Verification System (IEVS) - 5101:1-37-03.1**

This rule incorporates format changes to make it consistent with other rules contained in the Medicaid Eligibility Manual (MEM). The language in this rule is modified to include reference to rule 5101:1-37-01.1 of the Administrative Code for issues relating to recipient information disclosure and confidentiality.

Chapter 2

**Medicaid: Health Insurance Portability and Accountability Act (HIPAA) - 5101:1-38-01.5**

Rule 5101:1-2-99 is being rescinded and this rule replaces 5101:1-2-99 of the Ohio Administrative Code, which was the applicable HIPAA rule for the Medicaid program.

**Medicaid: Verification and Reporting Requirements - 5101:1-38-02**

This rule incorporates changes to make it consistent with other rules contained in the Medicaid Eligibility Manual (MEM). Language is added regarding rule 5101:1-37-01.1 of the Administrative Code for issues relating to recipient information disclosure and confidentiality.

Chapter 3

**Medicaid: Information Sharing with Long Term Care Facility (LTCF) Providers - 5101:1-39-12.2**

This rule incorporates changes to make it consistent with other rules contained in the Medicaid Eligibility Manual (MEM). The rule cite for the Medicaid rule on confidentiality and disclosure is corrected.

Chapter 5
Medicaid: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - "Healthchek" - 5101:1-38-05

Language is changed regarding frequency of Healthchek medical examinations. Language is also added regarding rule 5101:1-37-01.1 of the Administrative Code for issues relating to recipient confidentiality.

Medicaid: Pregnancy Related Services (PRS) - 5101:1-38-06

Language is added regarding rule 5101:1-37-01.1 of the Administrative Code for issues relating to recipient confidentiality.

Appendix

JFS Forms

**JFS 03528 - Healthchek and Pregnancy Services Assessment**

This form has a change in the language regarding the recipient’s signature. The change was made to make the JFS 3528 HIPAA compliant. The rules which reference the JFS 03528 are 5101:1-38-05, Medicaid: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - "Healthchek" and 5101:1-38-06, Medicaid: Pregnancy Related Services (PRS).

**JFS 03748 - Certificate of Group Health Plan Coverage**

This form has been revised and updated to incorporate a reference to the Disability Medical Assistance program and format changes. This form has a CRIS-E equivalent which will be revised as well. The rule which references the JFS 03748 is 5101:1-38-01.5, Medicaid: Health Insurance Portability and Accountability Act (HIPAA).

**JFS 03749 - Authorization for Certificate of Group Health Plan Coverage**

This form includes revisions to make it HIPAA compliant. The title of the JFS 03749 has been changed from the previous title, "Ohio Department of Job and Family Services Authorization to Release Medicaid/HIPAA Information" to "Authorization for Certificate of Group Health Plan Coverage". The rule which references the JFS 03749 is 5101:1-38-01.5, Medicaid: Health Insurance Portability and Accountability Act (HIPAA).

Appendix

Sample Forms

Suggested Format for Informed Release

This suggested format has been revised to be in compliance with HIPAA. When using this form, the administrative agency must include a signed HIPAA compliant authorization form.

Sample Format for Authorization for the Release or Use of Protected Health Information (PHI)

This sample format is adapted from the JFS 03397 (ODJFS Authorization form), which was developed by the ODJFS HIPAA Privacy Coordinating Committee. The administrative agency may use this sample format when releasing information to a third party, in accordance with rule 5101:1-37-01.1 of the Administrative Code.

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MEMTL 3 (Disclosure of Recipient Information and Confidentiality)

Medicaid Eligibility Manual Transmittal Letter No. 3

April 10, 2003

To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Disclosure of Recipient Information and Confidentiality.

This rule was developed to address the issues of disclosure of recipient information and confidentiality for Medicaid and other medical assistance programs.

The effective date of this MTL is April 14, 2003. If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MTL is available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/. The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 1
Medicaid: Disclosure of Recipient Information and Confidentiality 5101:1-37-01.1

Information has been added to this rule on the federal Health Insurance Portability and Accountability Act (HIPAA). The HIPAA privacy regulations have a mandated effective date of April 14, 2003. Medicaid and other medical assistance programs are subject to HIPAA. The significant changes to this rule related to HIPAA compliance are in 5101:1-37-01.1(C) and (F).

MEM Instructions:

MEMTL 2 (Citizenship and Eligibility for Victims of Trafficking)

Medicaid Eligibility Manual Transmittal Letter No. 2
March 21, 2003

TO: All Public Assistance Manual Holders
FROM: Tom Hayes, Director
SUBJECT: Medicaid: Citizenship and Benefit Eligibility for Victims of Trafficking

This Medicaid Eligibility Manual Transmittal Letter (MEMTL) reflects Medicaid specific program eligibility rules that were developed to continue the delinking between cash and medical assistance.

The effective date of this MEMTL is April 1, 2003. If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MTL is available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/oheligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at:
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Chapter 2

Medicaid: Citizenship 5101:1-38-02.3

This rule replaces 5101:1-2-30 of the Ohio Administrative Code, which was the applicable citizenship rule for the Medicaid program. The rule provides definitions and clarifies that an individual must be a citizen of the United States, a qualified alien or meet the exception statuses requirements identified within the rule to be eligible for the Medicaid program.

Medicaid: Benefit eligibility - Victims of Trafficking -5101:1-38-02.4

This is a Medicaid rule for victims of Trafficking. The Trafficking Victims Protection Act of 2000 makes adult victims of severe forms of trafficking eligible for benefits and services to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act (INA). This rule provides definitions, identifies the certification process and procedures for the county departments of job and family services.

Medicaid: Benefit eligibility - Indefinite Detainees/lifers- 5101:1-38-02.5

This rule is being created to provide language for individuals who are non-citizens, who after having served time for a criminal conviction and being given a final order of removal by the Immigration and Naturalization Service, remain in the United States because their country and no other country will accept them. These indefinite detainees or lifers may have come to the U.S. as refugees or may have a status that makes them eligible for refugee medical assistance benefits.

MEM Instructions:

Chapter 2

MEMTL 1 (Issuance of MEM)
Medicaid Eligibility Manual Transmittal Letter No. 1

January 3, 2003

TO: ALL MEDICAID ELIGIBILITY MANUAL HOLDERS
FROM: THOMAS J. HAYES, DIRECTOR
SUBJECT: ISSUANCE OF MEDICAID ELIGIBILITY MANUAL

This transmittal issues the Medicaid Eligibility Manual (MEM) effective immediately. With this issuance the Public Assistance Manual is obsolete because the MEM now houses all Medicaid eligibility policy. All previous written Medicaid clarifications and interpretational memo's (e.g. issued as District Director Letters) are also obsolete effective with this transmittal. The MEM is organized as follows:

- MEM Transmittal Letters
- ME Letters (previously PALs)
- Action Change Transmittal Letters
- Chapter 1 Introduction to Medicaid General Policy
- Chapter 2 Application Processing
- Chapter 3 Aged, Blind and Disabled (ABD)
- Chapter 4 Covered Families and Children (CFC)
- Chapter 5 Special Programs and Services
- MEM Appendix
  - JFS Forms
  - Other Agency Forms
  - Sample Forms
  - MEM Desk Aides
- Archived PAMTLs
- Archived PALs
- Obsolete ACTs

The ODJFS Bureau of Business Services has discontinued automatic distribution of paper handbook transmittal letters effective November 1, 2002. An electronic version of a complete Medicaid Eligibility Manual including the MTL is available on the Internet and may be accessed at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at http://www.state.oh.us/odjfs/lpc/calendar. The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.
Manual Eligibility Modernization Transmittal Letters (MEMMTLs) are authored by the Medicaid Eligibility Section. They provide a summary of new, revised and/or obsolete policies or rules. MEMMTLs are issued continuously as new regulations, policies and administrative decisions dictate. This letter introduces formal revisions to the Ohio Administrative Code rules and provides instruction of how to maintain the Medicaid Eligibility Manual.
MEMMTL 6 (Medicaid: Presumptive Eligibility)

Medicaid Eligibility Modernization Manual Transmittal Letter No. 6
April 27, 2015

To: All Medicaid Eligibility Modernization Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Presumptive Eligibility

This rule is amended effective April 25, 2015, for presumptive eligibility determinations using MAGI-based eligibility standards.

Chapter 6 Medicaid Eligibility Modernization

5160:1-1-62 Medicaid: presumptive eligibility

This rule describes the conditions under which an individual may receive time-limited medical assistance as a result of an initial, simplified determination of eligibility based on the individual's self-declared statements.

This rule is amended to make the following changes:

- Former foster care children are added as a group for whom presumptive eligibility (PE) determinations may be made;
- Language is added to specify that for PE there is to be a simplified determination of household composition; and
- Language is added to specify that third party vendors are prohibited from making PE determinations on behalf of a Qualified Entity (QE).

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http://www.odjfs.state.oh.us/lpc/calendar/
MEMMTL 5B (Medicaid: Presumptive Eligibility)

Medicaid Eligibility Modernization Manual Transmittal Letter No. 5B
March 27, 2014

To: All Medicaid Eligibility Modernization Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Presumptive Eligibility

As a result of changes discussed in Medicaid Eligibility Modernization Manual Transmittal Letter No. 1, which contains the rewritten administrative policy rules, the Ohio Department of Medicaid (ODM) is reviewing all existing Medicaid Administrative Code rules to modernize and simplify the rules where possible, and to update rule references where necessary. Some rules are being significantly rewritten, while others are simply being reviewed and updated.

This rule is effective March 31, 2014 for presumptive eligibility determinations using MAGI-based eligibility standards.

Chapter 6 Medicaid Eligibility Modernization

5160:1-1-62 Medicaid: presumptive eligibility

This rule describes the eligibility criteria for a time-limited presumptive eligibility benefit to allow time for a full determination of eligibility for medical assistance. It combines, renumbers and reorganizes existing rules 5160:1-2-40 and 5160:1-2-50, which address the presumptive eligibility criteria in effect through March 30, 2014 for children under age 19 and pregnant women.

This new rule describes the eligibility criteria in effect as of March 31, 2014 for presumptive eligibility determinations. As mandated by the Affordable Care Act, this rule also adds parents and caretaker relatives residing with a child under the age of 18 as a group that can have presumptive eligibility determinations.

The individual must be a (self-declared) resident of Ohio and a U.S. citizen or in a satisfactory immigrant status. The individual must also be one of the following:

1. A child under age nineteen with gross household income no greater than 206% of the federal poverty level (FPL) for the family size; or
2. A pregnant woman with gross household income no greater than 200% FPL for her family size; or
3. A parent or caretaker relative, residing with a child under the age of 18, with gross household income no greater than 90% FPL for the family size.

Eligibility criteria for these groups are not significantly changed by the Affordable Care Act, except for the addition of parents and caretaker relatives as a presumptive eligibility group with eligibility criteria substantially the same (except for the FPL threshold) as the other presumptive eligibility groups.

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Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEMMTL 4 (Medicaid: Eligibility Modernization Rules)

Medicaid Eligibility Modernization Manual Transmittal Letter No. 4
January 16, 2014

To: All Medicaid Eligibility Modernization Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility Modernization Rules

As a result of changes discussed in MEMMTL 1, published September 24, 2013, the Ohio Department of Medicaid is working to review all existing Medicaid Administrative Code rules to modernize and simplify the rules where possible, and to update rule references where necessary. Some rules are being significantly rewritten, while others are simply being updated and renumbered.

The rules in this transmittal are the third batch of modernized eligibility rules. These rules, and additional rules to follow, will eventually replace the current rules in the existing eligibility manual.

The effective date of the rules is January 1, 2014.

Chapter 6

5160:1-1-50.1 Medicaid: definitions
This rule is amended to include additional definitions related to rules in this MEMMTL.

5160:1-1-51.3 Medicaid: certificate of creditable coverage and privacy notice
This rule updates and replaces current rule 5160:1-2-01.5, but does not make substantive changes.

5160:1-1-51.4 Medicaid: outstationing workers at disproportionate share hospitals and federally qualified health centers
This rule updates and replaces current rule 5160:1-2-04. Additional clarification is added regarding federal outstationing requirements – these requirements are not new, but are now more clearly stated in rule.

5160:1-1-63.2 Medicaid: continuous eligibility for children younger than age nineteen
This rule updates and replaces current rule 5160:1-2-30, but does not make substantive changes.

5160:1-1-91 Medicaid: alien emergency medical assistance (AEMA)
This rule updates current rule 5160:1-5-20, but does not make substantive changes.

Form

JFS 03748 "Certificate of Group Plan Health Coverage" (Rev. 11/2013)
The revised form is an updated model certificate created by the U.S. Department of Labor and will be generated out of the new Ohio Integrated Eligibility System.

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**Internet Calendar:**  
http://www.odjfs.state.oh.us/lpc/calendar/
To: All Medicaid Eligibility Modernization Manual Holders
From: John B. McCarthy, Director
Subject: Form JFS 07216 "Application for Health Coverage and Help Paying Costs"

**Form**

**JFS 07216** "Application for Health Coverage and Help Paying Costs"

Beginning October 1, 2013, the Affordable Care Act required states to accept and use a "single streamlined application" that gathers information necessary to determine eligibility for Medicaid or subsidized health coverage through the federal marketplace.

As a result of new federal regulations as well as changes associated with the new Ohio Integrated Eligibility System, the Ohio Department of Medicaid (ODM) is replacing the JFS 07216 "Combined Programs Application" with the federally-designed single streamlined application, which will use the same form number JFS 07216 and be entitled "Application for Health Coverage and Help Paying Costs".

The new application asks questions related to federal income tax information that will be used in MAGI budgeting to determine Medicaid eligibility for MAGI covered groups. It also gives individuals the option to give their consent for ODM to obtain federal income tax information to complete automatic renewal of eligibility.

Copies of the "Combined Programs Application" that have already been printed will be used rather than destroyed. Applications submitted using any old versions of the form will still be accepted.

Form JFS 07216 is available from ODJFS Forms Central.

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MEMMTL 2 (Medicaid: Eligibility Modernization Eligibility Rules)

Medicaid Eligibility Modernization Manual Transmittal Letter No. 2
September 24, 2013

To: All Medicaid Eligibility Modernization Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility Modernization Eligibility Rules

As a result of changes discussed in Medicaid Eligibility Modernization Manual Transmittal Letter No. 1, which contains the rewritten administrative policy rules, the Ohio Department of Medicaid (ODM) is working to review all existing Medicaid Administrative Code rules to modernize and simplify the rules where possible, and to update rule references where necessary. Some rules are being significantly rewritten, while others are simply being reviewed and updated.

The rules in this transmittal, and additional rules to follow, will eventually replace the current rules in the existing eligibility manual after the new ODM Revised Code sections become formally available. As the old rules are updated, they will be renumbered and added to Chapter 6.

These rules are effective October 1, 2013 for determining MAGI-based eligibility for Medicaid coverage beginning on January 1, 2014.

Chapter 6 Medicaid Eligibility Modernization

5101:1-37-50 Medicaid: administrative code rule migration

This is a new rule describing which Administrative Code rules are effective for determining eligibility for the various categories of medical assistance on or after October 1, 2013.

5101:1-37-50.1 Medicaid: definitions

This rule contains definitions used in the new Administrative Code rules. As additional rules are proposed and more definitions are added, this rule will be revised. Some of the definitions in this rule are related to the new rules regarding MAGI-based eligibility categories.

Some of these definitions are unchanged from the current definitions rule. Other definitions have been revised as a result of the ACA or other changes. For example:

1. "Administrative agency" has been revised to reflect the separation of ODM from ODJFS.
2. "Authorized representative" has been revised for clarity.
3. "MAGI-based income" is a new ACA-based definition that is used in the new MAGI-based rules.

5101:1-37-55.1 Medicaid: authorized representative responsibilities

This is a new rule describing the responsibilities of an authorized representative in regard to the Medicaid program and Medicaid applicants or enrollees. This rule is based on current Administrative Code rules 5101:1-38-01 (Medicaid: Individual and Administrative Agency Responsibilities) and 5101:1-38-01.2 (Medicaid: Application, Determination, and Redetermination Processes). These responsibilities are being pulled together and explicitly stated as responsibilities of an authorized representative in the interest of clarity.

5101:1-37-58.2 Medicaid: United States (U.S.) citizenship documentation

This rule revises the U.S. citizenship documentation rule to address electronic verifications and to simplify the manual verification process when citizenship cannot be electronically verified.

5101:1-37-58.3 Medicaid: qualified aliens

This rule revises the documentation rule for non-citizen eligibility to address electronic verifications and to simplify the manual verification process when an individual's "satisfactory immigrant status" (a new term for eligible non-citizen status) cannot be electronically verified.

Medicaid: MAGI-Based Eligibility Categories
MAGI-based medicaid: income and household income

This rule directs the determination of an individual's personal income, household income and Medicaid household composition, including family size, as required by 42 C.F.R. 435.603, when determining eligibility for most categories of coverage previously considered family or child-based Medicaid.

This new household and income rule does not apply when an individual's eligibility is being determined for:

- Coverage because an individual is blind, disabled, or at least age 65, or in need of long-term care services and supports (whether in the home or in an institution), or for
- Medicare premium assistance (QMB, SLMB, QI-1).

The Affordable Care Act and the C.F.R. section cited above require the application of income and household composition rules created by the Internal Revenue Service (IRS) for tax purposes. In specified circumstances, however, a different set of household composition rules apply; those circumstances are described in this rule as well.

These new household and income rules will be reflected in the programming of the new Ohio Integrated Eligibility System. Training materials and desk aids have been developed and published.

MAGI-based medicaid: coverage for children younger than age nineteen

This rule describes Medicaid eligibility criteria for children from birth until the individual reaches age nineteen. The rule combines into one covered group all individuals younger than age 19, including deemed newborns, children in foster care, in the care of a child services agency, or receiving adoption assistance. Only two of the eligibility criteria in this rule were significantly changed by the ACA: first, a "child" is any individual under age 19; second, income limits have been adjusted as follows:

1. Children who are covered by other creditable insurance have a household income limit for the family size no greater than 156% FPL.
2. Children who are not covered by other creditable insurance have a household income limit for the family size no greater than 206% FPL.

MAGI-based medicaid: coverage for Ribicoff and former foster care adults

This rule describes Medicaid eligibility criteria for two groups of individuals.

1. Individuals who are age 19 or 20, with household income for the family size no greater than 44% FPL.
2. Individuals under the age of 26 who aged out of foster care at age 18.

Other than the adjustment of the income limit for Ribicoff children, eligibility criteria for these groups are not significantly changed by the ACA.

MAGI-based medicaid: coverage for pregnant women

This rule describes Medicaid eligibility criteria for pregnant women. These eligibility criteria are not significantly changed by the ACA, except that states must accept a woman's self-declaration of pregnancy.

For the purpose of determining a pregnant woman's family size, as described in rule 5101:1-37-61, a self-declaration of pregnancy will mean a woman counts as herself plus one individual when determining family size. If the woman is carrying multiple fetuses, medical verification would be required in order to add additional fetuses to family size.

MAGI-based medicaid: coverage for a parent or caretaker relative residing with a child

This rule describes Medicaid eligibility criteria for parents residing with their minor children. These eligibility criteria are not significantly changed by the ACA.
| Chapter 6 | N/A | **5101:1-37-50**  
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MEMMTL 1 (Medicaid: Eligibility Modernization Administrative Rules)

Medicaid Eligibility Modernization Manual Transmittal Letter No. 1

September 24, 2013

To: All Medicaid Eligibility Modernization Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Eligibility Modernization Administrative Rules

The Affordable Care Act of 2010 (ACA) requires that as of January 1, 2014, states use a new budgeting methodology when determining whether an individual might be eligible for Medicaid coverage as a child, a pregnant woman, or a parent or caretaker relative. This new "MAGI-based income" methodology, which is based upon income tax rules used to determine adjusted gross income, changes not just how income is calculated, but how a "household" is formed, who is considered part of an individual's Medicaid household, and whether or not a particular household member's income is counted in the eligibility budget.

In order to determine eligibility using this new budgeting methodology on the "real time" basis called for by the ACA, the Ohio Department of Medicaid (ODM) has implemented the new Ohio Integrated Eligibility System that will enable automated processing of many of the tasks that currently require a county worker's attention. This change to the new Ohio Integrated Eligibility System is prompting a review of Medicaid eligibility rules to remove or update process language as appropriate.

In addition, the Jobs 2.0 Executive Budget established the Ohio Department of Medicaid as a cabinet-level Medicaid agency effective July 1, 2013. This has impacted the numbering of Medicaid provisions in the Revised Code and the Administrative Code. Several new chapters will be created in Title 51 of the Revised Code to establish the new Department of Medicaid and its administrative functions. For the first time, these provisions will be organized according to subject matter (e.g., general Medicaid services, nursing facilities, managed care). In many instances, existing statutory language is being extracted or moved in its entirety from existing Chapters 5101, 5111, and 5112 of the Revised Code to the new chapters, with minimal changes.

As a result of these changes, ODM is working to review all existing Medicaid Administrative Code rules to modernize and simplify the rules where possible, and to update rule references where necessary. Some rules are being significantly rewritten, while others are simply being reviewed and updated. These new rules will be located in the newly-created Chapter 6 in the Medicaid Eligibility Manual, entitled Medicaid Eligibility Modernization.

The rules in this transmittal, and additional rules to follow, will eventually replace the current rules in the existing eligibility manual after the new ODM Revised Code sections become formally available. As the old rules are updated, they will be renumbered and added to Chapter 6.

These rules are effective October 1, 2013, for determining MAGI-based eligibility for Medicaid coverage beginning on January 1, 2014.

Chapter 6 Medicaid Eligibility Modernization

5101:1-37-51 Medicaid: administrative agency responsibilities

This rule describes the responsibilities of the administrative agency in regard to the Medicaid program and Medicaid applicants or enrollees. This rule is based on current Administrative Code rules 5101:1-38-01 (Medicaid: Individual and Administrative Agency Responsibilities) and 5101:1-38-01.2 (Medicaid: Application, Determination, and Redetermination Processes). The new rule has been reorganized for clarity.

Some of the responsibilities in this rule are impacted by ACA requirements and the new eligibility system under development. For example, when an individual requests an application, the agency is to inform the individual that using the on-line application portal is likely to result in a faster eligibility determination. Also, whether or not the individual applied via the on-line portal, the administrative agency is to use the electronic eligibility system to obtain electronic verification of eligibility criteria, and request manual verification from an applicant only when electronic verification is unavailable or inconsistent with information provided by the applicant.
5101:1-37-51.1 Medicaid: safeguarding and releasing information
This rule describes the responsibilities of the administrative agency to safeguard information related to Medicaid and medical assistance, and release it only when appropriate. This rule is based on current Administrative Code rule 5101:1-37-01.1 and has been revised for clarity, but the agency responsibilities have not changed.

5101:1-37-51.2 Medicaid: consumer fraud and erroneous payments
This rule describes the responsibilities of the administrative agency upon receipt of a report of fraud or abuse by a Medicaid consumer. This rule is based on current Administrative Code rule 5101:1-38-20 and has been revised for clarity, but the agency responsibilities have not changed.

5101:1-37-55 Medicaid: individual responsibilities
This rule describes the responsibilities of an individual, or an authorized representative of an individual, applying for or receiving Medicaid. This rule is based on current Administrative Code rules 5101:1-38-01 (Medicaid: Individual and Administrative Agency Responsibilities) and 5101:1-38-01.2 (Medicaid: Application, Determination, and Redetermination Processes). The new rule has been reorganized for clarity.

5101:1-37-58 Medicaid: conditions of eligibility and verifications
This rule sets forth the conditions an individual applying for or receiving any category of Medicaid must meet in order to be eligible. The rule also clarifies when an individual's statement may be accepted as sufficient verification and when electronic or manual verifications must be obtained. This rule is based on current Administrative Code rule 5101:1-38-01.8 (Medicaid: conditions of eligibility for each individual). The new rule has been reorganized for clarity. Some of the verification requirements or processes are revised by the ACA. Specifically, the ACA requires that states accept self-attestation of certain criteria and that individuals be asked to provide verification of any eligibility criteria only when electronic verification has failed.

5101:1-37-58.1 Medicaid: restrictions on payment for services
This rule specifies when payment for services is not available for an individual who is eligible for and enrolled in Medicaid. This rule is based on current Administrative Code rule 5101:1-37-20 (Restrictions on payment for services). The new rule has been reorganized for clarity.

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<td>5101:1-37-51</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective 10/1/2013)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5101:1-37-51.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective 10/1/2013)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5101:1-37-51.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective 10/1/2013)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5101:1-37-55</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective 10/1/2013)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5101:1-37-58</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective 10/1/2013)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>5101:1-37-58.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective 10/1/2013)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:
ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
Medicaid Eligibility Procedure Letters (MEPLs) will replace the designation of the Action Change Transmittal (ACT) and the Medicaid Information Letter (MIL). MEPLs are authored by the Medicaid Eligibility Policy Section to quickly relay policy changes or introduce a special project. MEPLs are used when it is required to communicate a change in policy prior to incorporating the change into the Medicaid Eligibility Manual. They are also used to notify of a policy change that does not originate in the department (e.g. federal poverty index). MEPLs are signed by the director, considered policy and must be implemented.
MEPL 99 (Medicaid: 2015 Federal Poverty Level Income Guidelines for MBIWD)

Medicaid Eligibility Procedure Letter No. 99

March 12, 2015

Effective Date: January 1, 2015

OAC Rules: 5160:1-5-03

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2015 Federal Poverty Level Income Guidelines for Medicaid Buy-In for Workers with Disabilities (MBIWD)

Reason for Change: On January 21, 2015, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guideline for the MBIWD program has changed effective January 1, 2015.

Actions Required: Beginning January 1, 2015, the CDJFS must determine initial and ongoing eligibility for the MBIWD individual using the updated 250% FPL income guideline below:

<table>
<thead>
<tr>
<th>MBIWD 2015 Monthly FPL Income Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Income Guideline 250%</td>
</tr>
<tr>
<td>$2,453</td>
</tr>
</tbody>
</table>

Beginning January 1, 2015, the CDJFS must determine MBIWD premiums using the updated 150% and 450% FPL guidelines below:

<table>
<thead>
<tr>
<th>2015 Monthly FPL Income Guidelines for Premium Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

A mass change will not be run for MBIWD individuals; however, instructions regarding how to generate the necessary reports using the Business Intelligence Channel (BIC) are available in the Medicaid Eligibility Manual in a desk aid entitled, "MBI WD FPL BIC Report Instructions."

For any assistance groups (AG's) identified as denied or terminated since January 1, 2015, using the previous year's FPL income guidelines, counties must redetermine eligibility using the updated FPL, which are also found in CRIS-E table TMEP. To determine whether eligibility needs to be redetermined in an AG listed on the closure report:

1. Verify why the AG was listed on the report by looking at AEWAA history screens for the authorization date and reason code(s). If the AG was denied or terminated due to income, go on to step 2.
2. Review IQCT: If AEORE or AEABC was last run before February 17, 2015, re-run the AG to redetermine eligibility.

For individuals who are already approved for MBIWD, the CDJFS is required to rerun the budgets, which includes recalculating the premium. When the CDJFS has determined that the updated premium is lower, the CDJFS must reduce the individual's premium obligation; however, if the updated premium is higher, the CDJFS shall not increase the premium until the MBIWD individual's annual redetermination.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td><strong>MEPL 88</strong></td>
<td><strong>MEPL 99</strong></td>
</tr>
<tr>
<td></td>
<td>(Effective Jan 1, 2014)</td>
<td>(Effective Jan 1, 2015)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 88 is obsolete upon the effective date of this MEPL.

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

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http://www.odjfs.state.oh.us/lpc/calendar/staff/  

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 98 (Medicaid: 2015 Federal Poverty Level Income Guidelines for Low-Income MPAP)

Medicaid Eligibility Procedure Letter No. 98

March 12, 2015

Effective Date: March 1, 2015

OAC Rules: 5160:1-3-02.1, 5160:1-3-02.2, and 5160:1-3-03.5

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2015 Federal Poverty Level Income Guidelines for Low-Income Medicare Premium Assistance Programs (MPAP)

Reason for Change: On January 21, 2015, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: Federal poverty level income guidelines for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective March 1, 2015.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRIS-E in table TMEP. The increased amounts for 2015 are in bold print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>$981</td>
<td>$1,328</td>
</tr>
<tr>
<td>100% FPL</td>
<td>$973 (2014)</td>
<td>$1,311 (2014)</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB)</td>
<td>$1,177</td>
<td>$1,593</td>
</tr>
<tr>
<td>(SLMB) 120% FPL</td>
<td>$1,167 (2014)</td>
<td>$1,573 (2014)</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1)</td>
<td>$1,325</td>
<td>$1,793</td>
</tr>
<tr>
<td>135% FPL</td>
<td>$1,313 (2014)</td>
<td>$1,770 (2014)</td>
</tr>
<tr>
<td>Qualified Working Disabled Individuals (QWDI)</td>
<td>$1,962</td>
<td>$2,655</td>
</tr>
<tr>
<td>200% FPL</td>
<td>$1,945 (2014)</td>
<td>$2,622 (2014)</td>
</tr>
</tbody>
</table>

Action Required: Table TMEP will be updated before CRIS-E’s adverse action cut off for April budgets. The change will automatically recalculate budgets on authorized assistance groups (AG’s). For AG’s where the mass change was not completed, the system generates alert #372 instructing the case manager to rerun the budgets. Counties must rerun these AG’s to update the cost-of-living adjustment (COLA) increases.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 87 (Effective March 1, 2014)</td>
<td>MEPL 98 (Effective March 1, 2015)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 87 is obsolete upon the effective date of this MEPL.
This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
Medicaid Eligibility Procedure Letter No. 97
March 12, 2015

Effective Date: January 1, 2015


To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: 2015 Federal Poverty Level Income Guidelines for MAGI-Based Medicaid

Reason for Change: On January 21, 2015, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guidelines for the MAGI-Based Medicaid programs have changed effective January 1, 2015.

Action Required: Beginning January 1, 2015, the CDJFS must determine initial and ongoing eligibility for MAGI-Based Medicaid using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Individuals Age 19 or 20 44%</th>
<th>Parent or Caretaker Relative 90%</th>
<th>MAGI Adults 133%</th>
<th>Coverage for Children 156%*</th>
<th>Pregnant Women 200%</th>
<th>Coverage for Children 206%**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$432</td>
<td>$883</td>
<td>$1,305</td>
<td>$1,531</td>
<td>$1,962</td>
<td>$2,021</td>
</tr>
<tr>
<td>2</td>
<td>$585</td>
<td>$1,195</td>
<td>$1,766</td>
<td>$2,071</td>
<td>$2,655</td>
<td>$2,735</td>
</tr>
<tr>
<td>3</td>
<td>$737</td>
<td>$1,507</td>
<td>$2,227</td>
<td>$2,612</td>
<td>$3,349</td>
<td>$3,449</td>
</tr>
<tr>
<td>4</td>
<td>$890</td>
<td>$1,819</td>
<td>$2,688</td>
<td>$3,153</td>
<td>$4,042</td>
<td>$4,163</td>
</tr>
<tr>
<td>5</td>
<td>$1,042</td>
<td>$2,131</td>
<td>$3,149</td>
<td>$3,694</td>
<td>$4,735</td>
<td>$4,878</td>
</tr>
<tr>
<td>6</td>
<td>$1,195</td>
<td>$2,443</td>
<td>$3,610</td>
<td>$4,235</td>
<td>$5,429</td>
<td>$5,592</td>
</tr>
</tbody>
</table>

*This standard is used for children with creditable insurance.

**This standard is used for children without creditable insurance.

Action Required: The FPL table in Ohio Benefits will be updated with the 2015 FPLs before cut-off for April budgets. A desk review is required for MAGI cases that failed from January 1, 2015 to March 31, 2015 for ‘Over Income’ using the 2014 FPLs. A report will be generated of the failed cases.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 86 (Effective January 1, 2014)</td>
<td>MEPL 97 (Effective January 1, 2015)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 86 is obsolete upon the effective date of this MEPL.
This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
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**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 96 (Medicaid: Ninety Day Reinstatement)

Medicaid Eligibility Procedure Letter No. 96

February 6, 2015

Effective Date: February 1, 2015

OAC Rules: 5160:1-1-51

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Ninety Day Reinstatement

Reason for Change: Federal Regulation 42 C.F.R. 435.916 requires states to reconsider eligibility for modified adjusted gross income (MAGI) Medicaid, without requiring a new application, if an individual complies within ninety days of being terminated for failure to submit the renewal form or necessary verifications. The Centers for Medicare and Medicaid Services has included Non-MAGI Medicaid eligibility in the reconsideration process for renewals.

Ohio has included in the reconsideration process terminations for failure to cooperate in the verification of a reported change.

New Policy: Reinstatement of Medicaid eligibility when an individual complies within ninety days of termination.

Action Required: The administrative agency shall reinstate Medicaid eligibility, terminated for failure to cooperate in the renewal process or verification of a reported change, within ninety days of the termination date without requiring a new application.

The administrative agency shall accept the renewal form and/or verifications that caused the termination of Medicaid.

Reinstated Medicaid eligibility shall begin on the first day of the calendar month following the month Medicaid was terminated.

A CRIS-E View Flash Bulletin (CLVB) and OIES Portal Announcement will be issued with this information.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>N/A</td>
<td>MEPL 96 (Effective 2/1/15)</td>
</tr>
</tbody>
</table>

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**ODJFS Electronic Manuals**

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http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 95B (Correction to MPAP Resource Limit for an Individual)

Medicaid Eligibility Procedure Letter No. 95B

February 6, 2015

Effective Date: March 1, 2015

OAC Rules: 5160:1-3-02.1

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Correction to Medicare Premium Assistance Program (MPAP) Resource Limit for an Individual

Reason for Change: A correction was made to the Medicare Premium Assistance Program (MPAP) resource limit for an individual. MEPL 95 contained an incorrect amount.

The table in this MEPL has a limit for 2015 in bold, along with the 2014 numbers for reference.

MPAP Resource Limit

<table>
<thead>
<tr>
<th>MPAP RESOURCE LIMIT</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,160</td>
<td>$7,280</td>
</tr>
</tbody>
</table>

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

Table TMEP is updated to reflect the corrected MPAP resource limit for an individual; this new figure should be used for resource calculations as described in rule 5160:1-3-02.1.

Action Required

A desk review is required for denied or terminated MPAP cases in CRIS-E for budget months January and February 2015 with reason code 708 "QMB, SLMB, QI-1 Denied, Countable Resources Exceed Limit".

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>N/A</td>
<td>MEPL 95B (Effective March 1, 2015)</td>
</tr>
</tbody>
</table>

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http://www.odjs.state.oh.us/lpc/calendar/
**MEPL 95A (Home Equity Limit Adjustment)**

*Medicaid Eligibility Procedure Letter No. 95A*

December 19, 2014

**Effective Date:** February 1, 2015

**OAC Rules:** 5160:1-3-05.13

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Home Equity Limit Adjustment

**Reason for Change:** On November 25, 2014, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin with the final numbers for Spousal Impoverishment Standards. The bulletin provided an increased amount for the home equity value limit than previously calculated in MEPL 95.

The table in this MEPL has the new limit for 2015 in bold, along with the 2014 number for reference.

**Home Equity Limit**

The home equity limit increase for 2015.

<table>
<thead>
<tr>
<th>HOME EQUITY LIMIT AMOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Maximum amount of equity an individual can have in a home</td>
</tr>
</tbody>
</table>

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td></td>
<td>MEPL 95A (Effective February 1, 2015)</td>
</tr>
</tbody>
</table>

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http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 95 (Medicaid: January 2015 COLA)

Medicaid Eligibility Procedure Letter No. 95

December 10, 2014

Effective Date: January 1, 2015


To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: 2015 Social Security Cost of Living Adjustment (COLA)

State Minimum Wage Increase

Home Equity Value Increase

Consumer Price Index (CPI) Increase

Supplemental Security Income (SSI) Benefit Increase

Railroad Retirement Benefit Increase

Veterans Administration Benefit Increase

Residential State Supplements (RSS) COLA Disregard

Medicare Part B Premium Change

Medicaid Need Standards Increase

Special Income Level (SIL) Increase

Assisted Living Maintenance Needs Allowance (ALMNA) Increase

Special Individual Maintenance Needs Allowance (SIMNA) Increase

Spousal Impoverishment Standards Increase

MBIWD Resource Eligibility Limit Increase

Medicare Premium Assistance Program (MPAP) Resource Limit Increase

Student Child Earned Income Exclusion Increase

Personal Needs Allowance (PNA) Increase

Reason for Change: ODM is required to make annual adjustments-based on the Social Security COLA and changes to the Consumer Price Index (CPI)- to the following: Social Security income, SSI, railroad retirement benefits, Veterans Administration (VA) benefits, the RSS disregard, Medicare Part B premium, the home equity value limit, spousal impoverishment standards, Medicaid need standards, special income level, assisted living maintenance needs allowance, special maintenance needs allowance, MBIWD resource eligibility limit, MPAP resource limit, changes in the student child earned income exclusion, and certain veterans administration income.
The application of the COLA increase in VA benefits is new for 2015, and due to system limitations, will only be updated in OIES for individuals receiving VA aid and attendance, VA survivor benefits, and VA disability benefits.

ODM is required to annually update the state minimum wage, based upon the Ohio Department of Commerce Division of Industrial Compliance and Labor's annual increase to the state minimum wage.

ODM is required to increase the Personal Needs Allowance (PNA) for nursing facility residents in 2015, per Amended Substitute House Bill 59 of the 130th General Assembly.

The tables in this MEPL have limits, standards, benefits, and/or payment amounts for 2015 in bold, along with the 2014 numbers for reference.

Social Security, Veteran Administration, and railroad retirement benefits will increase by 1.7% January 1, 2015. The CDJFS must enter the gross amount of all individuals’ Social Security, railroad retirement, and Veteran Administration benefits on CRIS-E screen AEFMI and in OIES.

The 2015 COLA increase for Social Security and railroad retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals until February 28, 2015 in CRIS-E only. OIES is currently not programmed with functionality for QMB, SLMB, or QI-1. For QMB, SLMB, or QI-1 individuals, the COLA is only disregarded for the QMB, SLMB, or QI-1 financial eligibility determinations.

In 2015, there will also be increases in the home equity limit, the RSS COLA disregard, Medicaid need standards, special income level, assisted living maintenance needs allowance, special individual maintenance needs allowance, spousal impoverishment standards, MBIWD resource limit, MPAP resource limit, and the student child earned income exclusion. Medicare Part B premiums will not increase for 2015.

Note: It is anticipated that in 2015, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards. Information regarding the necessary CDJFS activity for these changes will be provided in a future MEPL.

**Personal Needs Allowance**

Effective January 1, 2015, the PNA for an individual residing in a nursing facility increases to $50, plus up to an additional sixty-five dollars of gross earnings received as a result of employment, for a possible maximum PNA of $115.

For an individual residing in an ICF/IID, the PNA will remain at the current amount of $40, plus up to an additional sixty-five dollars of gross earnings received as a result of employment, for a possible maximum PNA of $105.

**State Minimum Wage**

The state minimum wage increases from $7.95 per hour to $8.10 per hour, effective January 1, 2015.

**Home Equity Limit**

The home equity limit will increase for 2015.

<table>
<thead>
<tr>
<th>HOME EQUITY LIMIT AMOUNTS</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum amount of equity an individual can have in a home</td>
<td>$543,000</td>
<td>$551,000</td>
</tr>
</tbody>
</table>

**Social Security and Railroad Retirement Benefits**

Social Security benefits, Veteran Administration benefits, and railroad retirement benefits will increase for 2015.

**SSI Increase**

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Single individual living independently</td>
</tr>
<tr>
<td>Couple living independently</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

**RSS Individuals**

The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

**DISREGARD OF SSI COLA INCREASE**

<table>
<thead>
<tr>
<th></th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014</td>
<td>2015</td>
<td>2014</td>
</tr>
<tr>
<td>Maximum single individual SSI benefit</td>
<td>$721</td>
<td>$733</td>
<td>$11</td>
</tr>
<tr>
<td>Maximum couple SSI benefit</td>
<td>$1,082</td>
<td>$1,100</td>
<td>$16</td>
</tr>
</tbody>
</table>

**Medicare Premium**

**MEDICARE PART B PREMIUM**

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$104.90</td>
<td>$104.90*</td>
</tr>
</tbody>
</table>

* A Medicare beneficiary whose modified adjusted gross income is greater than $85,000 (individual) or $170,000 (filing a joint tax return) is responsible for a larger portion of the cost of Part B coverage. Therefore, in addition to the standard premium such a beneficiary must pay an income-related monthly adjustment amount.

**Medicaid Need Standard for Individual/Couple in Own Household**

**MEDICAID NEED STANDARDS**

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$632</td>
<td>$643</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$1,082</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Household of Another**

**MEDICAID NEED STANDARDS**

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$422</td>
<td>$429</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$722</td>
<td>$734</td>
</tr>
</tbody>
</table>
### Special Income Level

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$2,163</td>
<td>$2,199</td>
</tr>
</tbody>
</table>

### Assisted Living Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$721</td>
<td>$733</td>
</tr>
</tbody>
</table>

### Special Individual Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1,406</td>
<td>$1,430</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards

<table>
<thead>
<tr>
<th>IMPOVERISHMENT STANDARDS</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$23,448</td>
<td>$23,844</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$117,240</td>
<td>$119,220</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,931</td>
<td>$2,981</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2015.

### MBIWD Resource Eligibility Limit

<table>
<thead>
<tr>
<th>MBIWD RESOURCE ELIGIBILITY LIMIT</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$11,281</td>
<td>$11,473</td>
</tr>
</tbody>
</table>

### MPAP Resource Limit

<table>
<thead>
<tr>
<th>MPAP RESOURCE LIMIT</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,160</td>
<td>$7,260</td>
</tr>
</tbody>
</table>
### Student Child Earned Income Exclusion

<table>
<thead>
<tr>
<th>STUDENT EXCLUSION</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (per quarter)</td>
<td>$1,750</td>
<td>$1,780</td>
</tr>
<tr>
<td>Earned income exclusion (per year)</td>
<td>$7,060</td>
<td>$7,180</td>
</tr>
</tbody>
</table>

The student child earned income exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

### Long Term Care Facility (LTCF) Individuals

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5160:1-3-04.3 and 5160:1-3-04.4.

After the mass change is run, ODM will issue report BON003-R002 as in past years; this report is a summary of all individuals by LTCF.

Because of the increase in patient liability, case workers must issue prior notice for adverse action by the adverse action cutoff date of December 15, 2014 in order to avoid an error. If the adverse action notice is issued after the December 15 cutoff, then the increase cannot be effective until February 1, 2015.

### CRIS-E

CRIS-E performs a mass change beginning November 27, 2014 to update items listed in this MEPL effective January 1, 2015.

- CRIS-E will generate alerts to case workers regarding cases updated by the mass change.
- To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.
- The CDJFS must provide notice to individuals bypassed during mass change, in accordance with OAC 5101:6-2-04.
- CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the last day of the month following the month that the publication of the revised annual federal poverty level is issued.

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

Table TWAG is updated to reflect the increased state minimum wage amount; this new figure should be used for income calculations as described in rules 5160:1-2-01.9 and 5160:1-5-03. Other increased amounts can be found on updated tables TExM and TMEP.

### Action Required

No desk review is required for cases in CRIS-E with VA benefits. The CDJFS must update AEFMI when notified of a change in VA benefits.

### MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
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</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 83 (Effective January 1, 2014)</td>
<td>MEPL 95 (Effective January 1, 2015)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 94 (Medicaid: Implementing 2101(f)-Like Protection for Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards)

Medicaid Eligibility Procedure Letter No. 94

October 31, 2014

Effective Date: January 1, 2015

OAC Rule: 5160:1-4-02

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Implementing 2101(f)-Like Protection for Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

Reason for Change: With the transition to determining income eligibility for children using a methodology based on modified adjusted gross income (MAGI), Congress was concerned that children might lose Medicaid eligibility as a result of the elimination of income disregards. In order to ensure continuity of coverage for children during this transition, section 2101(f) of the Affordable Care Act (ACA) requires that states treat any child determined ineligible due to the differing budget methodologies - specifically, the reduced application of income disregards - as a targeted low-income child and provide health assistance to the child in a separate CHIP. Because Ohio does not operate a separate CHIP program, these children will remain eligible in the state's (Medicaid-expansion) CHIP program.

Children who otherwise would lose Medicaid eligibility due to the elimination of income disregards will remain categorically eligible based on their enrollment in Medicaid on December 31, 2013.

Prior Policy: When a child's eligibility was redetermined at the end of the child's year of Continuous Eligibility, coverage was terminated if the child was determined ineligible for health coverage for any reason.

New Policy: All of a child's household income will be disregarded, for one annual eligibility determination only, when the child's eligibility is being redetermined using MAGI methodologies for the first time and the child:

- Was enrolled in Medicaid on December 31, 2013;
- Is ineligible for Medicaid solely as a result of the elimination of income disregards;
- Is not otherwise eligible for any category of Medicaid; and
- Is not an inmate of a public institution or a patient in an institution for mental diseases.

A child found eligible as a result of this disregard will remain eligible until the child's next scheduled annual review (12 months following the first renewal where MAGI methodologies are applied), with the following exceptions:

- The child reaches age 19;
- The child moves out of state;
- Voluntary disenrollment is requested; or
- The child dies.

Action Required: Due to the waiver of annual redeterminations during calendar year 2014, this will result in children currently enrolled in pre-ACA Medicaid coverage who would no longer be eligible for Medicaid under the MAGI budgeting methodology at the 2015 annual redetermination remaining on Medicaid until the 2016 annual redetermination date.

A lack of changes in household composition, household income, and citizenship status are indicators that a child has lost eligibility solely due to the elimination of disregards.

Children who were previously eligible as a Medicaid child shall have eligibility continued under the 4122 aid code, while children who were previously eligible as a CHIP child shall have eligibility continued under the 4123 aid code.
A CLVB and an OIES Portal Announcement are issued with the information contained in this MEPL.

**MEM Instructions:**

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<thead>
<tr>
<th>Location</th>
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<tr>
<td>MEPLs</td>
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<td>MEPL 94 (Effective 01/01/2015)</td>
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</table>

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http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 93 (Medicaid: Standard Utility Allowance Increase)

Medicaid Eligibility Procedure Letter No. 93

November 6, 2014

Effective Date: October 1, 2014

OAC Rule: 5160:1-3-24

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Standard Utility Allowance Increase

Reason for Change: The Ohio Department of Job and Family Services Office of Family Assistance, with approval from the Food and Nutrition Service, is increasing the standard utility allowance (SUA) from $463 to $498. As a result of the increase in the Food Assistance Program's standard utility allowance, the SUA for determination of the minimum monthly maintenance needs allowance (MMMNA) is also being increased.

Ohio's SUA from the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the community spouse's MMMNA as part of the institutionalized spouse's patient liability calculation.

The MMMNA is used when determining the monthly income allowance (MIA) for a community spouse. The MIA, in turn, is deducted during the calculation of the institutionalized spouse's patient liability in order to account for the needs of the community spouse. The MIA is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2014) standard as well as the increased amount for 2015 (in bold).

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Utility Allowance</td>
<td>$463</td>
<td>$498</td>
</tr>
</tbody>
</table>

Action Required: For budgets effective on or after October 1, 2014, the standard utility allowance of $498 shall be used when determining the community spouse's MIA.

A review of all long term care facility (LTCF) and home and community-based services (HCBS) covered groups with a community spouse must be completed prior to the October 1, 2014 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance.

These cases, with MIA for the community spouse (MA M), can be identified by utilizing the caseload query system available in CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All covered groups affected by the increased utility allowance shall be provided with written notice of proposed action.

Effective October 1, 2014, all new applicants must have eligibility determined using the utility standard of $498.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new standard utility allowance can be found in CRIS-E reference table TMEP.

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<tr>
<th>Location</th>
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<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 82 (Effective 10/01/2013)</td>
<td>MEPL 93 (Effective 10/01/2014)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:
MEPL 92 (Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities)

Medicaid Eligibility Procedure Letter No. 92

August 19 2014

Effective Date: September 1, 2014

OAC Rule: 5160:1-3-07

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities

Reason for Change: The Ohio Department of Aging has provided an updated average private pay rate for nursing facilities. The new rate is effective September 1, 2014.

Prior Policy: The previous average private pay rate, last updated in 2013, was $6,114.

New Policy: The updated private pay rate for nursing facilities is $6,327.

Action Required: A new period of restricted coverage is not computed for individuals currently in a penalty period. The CDJFS should not re-compute an improper transfer penalty period unless there is new information regarding the improper transfer (e.g. the resource was returned to the individual). The original notice that was issued to the consumer is still valid.

For new periods of restricted coverage calculated on or after September 1, 2014, the CDJFS is required to use the updated average private pay rate to calculate the penalty period.

CRIS-E reference table TMEP has been updated to reflect this increase for recurring budgets effective September 1, 2014.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
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<td>MEPLs</td>
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<td>MEPL 92 (effective 9/1/14)</td>
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http://emanuals.odjfs.state.oh.us/emanuals/

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Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 91 (Medicaid: 2014 MMMNA and ESA Standards)

Medicaid Eligibility Procedure Letter No. 91

August 1, 2014

Effective Date: July 1, 2014

OAC Rule: 5160:1-3-24

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2014 Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason for Change: Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines, per federal requirements established in 42 U.S.C. 1396r-5(d)(3)(A).

The Department of Health and Human Services provided the updated FPL guidelines in January, 2014, making July 1, 2014, the effective date for the new MMMNA and ESA standards.

Policy: The following Medicaid standards are affected by the increase in the FPL. This table shows the 2013 standards and the 2014 standards in bold.

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMMNA Standard</td>
<td>$1,939</td>
<td>$1,967</td>
</tr>
<tr>
<td>ESA Standard</td>
<td>$582</td>
<td>$590</td>
</tr>
</tbody>
</table>

Action Required: No case alerts will be issued and there will not be a mass change completed by CRIS-E. Therefore, a manual review of all long term care facility and home & community based services assistance groups with a community spouse will need to be completed. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. The standards can also be found on CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
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<td></td>
<td>MEPL No. 91</td>
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<tr>
<td></td>
<td>MEPL No. 79</td>
<td>(Effective July 1, 2013)</td>
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<tr>
<td></td>
<td>MEPL No. 91</td>
<td>(Effective July 1, 2014)</td>
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InnerWeb Calendar:
http://www.odjs.state.oh.us/lpc/calendar/staff/

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http://www.odjs.state.oh.us/lpc/calendar/
Reason for Change: For calendar year 2014, annual redeterminations are waived except in situations where the covered individual has a significant change in circumstances. This is part of the transition to the MAGI budgeting methodology.

Prior Policy: Eligibility for Medicaid was required to be redetermined annually or upon report or discovery of a change.

New Policy: During calendar year 2014, redeterminations will only be conducted upon report or discovery of a "significant change" in the individual’s circumstances. Effective January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) approved Ohio’s definition of the significant changes that require a Medicaid redetermination during 2014. Annual redeterminations will resume in calendar year 2015.

Action Required: Beginning January 1, 2014, the CDJFS must redetermine eligibility for any individual enrolled in Medicaid in the following situations:

- If there is a change in one or more of an individual’s demographic factors, specifically:
  - An individual moves out of Ohio
  - An individual moves into or out of a Medicaid household
  - An individual is born or dies
  - An individual reaches a trigger age
    - Age 18 (for a child who is the basis of an individual’s coverage as a parent or caretaker relative)
    - Age 19
    - Age 21
    - Age 26 (for an individual who aged out of foster care)
    - Age 65
  - An individual experiences a limiting physical factor (LPF) change, such as:
    - Determination of blindness or disability
    - Determination that the individual is not blind or disabled
- If an individual who is subject to Ohio Works First (OWF) work requirements receives a third tier work sanction for a third failure to comply with work-related requirements
- If an individual fails to comply with applicable child medical support cooperation requirements

Eligibility must also be redetermined for any individual receiving aged, blind, disabled, or waiver Medicaid upon report or discovery of an increase in the individual’s assets.

In addition, eligibility must be redetermined for any individual subject to a spenddown, a premium, or a patient liability upon report or discovery of a change in the individual’s income.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL.

MEM Instructions:
This information is also available on the Internet and may be accessed at:

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**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
Effective Date:    March 1, 2014
OAC Rules:  5160:1-3-19
To:    All Medicaid Eligibility Manual Holders
From:  John B. McCarthy, Director
Subject:  Medicaid: ABD Deeming Calculator Update - 2014 Federal Poverty Levels


New Policy:  The ABD deeming calculator has been updated with the 2014 federal poverty level income guidelines for the Medicare Premium Assistance Programs (MPAP):  Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid.

The new federal poverty level guidelines will be effective beginning with the March 2014 budget month.

Action Required:  Use the newest version of the ABD deeming calculator, found on the County Resources website, when performing budget calculations for ABD deeming cases where the applicant is also applying for any MPAP program.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
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<th>Replace/Insert</th>
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<td>MEPLs</td>
<td><strong>MEPL 78</strong></td>
<td><strong>MEPL 89</strong></td>
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<tr>
<td></td>
<td>(Effective March 1, 2013)</td>
<td>(Effective March 1, 2014)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 78 is obsolete upon the effective date of this MEPL.

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
Effective Date: March 31, 2014

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Presumptive Eligibility for Extension Adults

New Policy: As of March 31, 2014, County Departments of Job and Family Services and Qualified Providers are authorized to do Presumptive Eligibility determinations for adults ages 19 through 64 with income at or below 133% of the Federal Poverty Level (FPL), as defined in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and described in MEPL 84.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
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<th>Insert</th>
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<tbody>
<tr>
<td>MEPLs</td>
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This information is also available on the Internet and may be accessed at:

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InnerWeb Calendar:
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Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 85B (Medicaid: Hospital Presumptive Eligibility)

Medicaid Eligibility Procedure Letter No. 85B

March 27, 2014

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Hospital Presumptive Eligibility

New Policy: As of March 31, 2014, hospitals will be allowed to make presumptive eligibility determinations for a number of covered groups, including the group consisting of adults ages 19 through 64 with income at or below 133\% of the Federal Poverty Level (FPL) described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Such determinations of presumptive eligibility by hospitals are done through a newly-developed provider portal.

MEM Instructions:

<table>
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<tr>
<th>Location</th>
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<tr>
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<td>MEPL 85B (Effective 3/31/14)</td>
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**InnerWeb Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 84 (Medicaid: Coverage for certain individuals with income at or below 133% of Federal Poverty Level)

Medicaid Eligibility Procedure Letter No. 84

December 9, 2013

Effective Date: December 9, 2013

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Coverage for certain individuals with income at or below 133% of Federal Poverty Level

New Policy: On October 21, 2013, Ohio’s Controlling Board approved the use of federal funds, authorized under the Affordable Care Act, to provide Medicaid coverage for certain individuals with income at or below 133% of the Federal Poverty Level (FPL) described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Coverage for these individuals begins on or after January 1, 2014.

Individuals eligible for coverage must:

1. Be at least nineteen years old but less than sixty-five years old.
2. Not be pregnant.
3. Not be enrolled in or eligible for coverage under Medicare Part A or Part B.
4. Have household income no more than 133% FPL using MAGI budgeting.
5. Not be eligible for coverage under another category of full Medicaid except for individuals with a spenddown.

If the individual is a parent or caretaker relative of a child and resides with that child, that child must have creditable coverage through Medicaid or other creditable coverage before the individual is eligible for coverage under this program.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
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InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
Reason for Change: The Ohio Office of Budget and Management has increased the state mileage rate from $.45 to $.52. The state mileage rate is used as an income deduction when calculating countable income for Medicaid eligibility.

Prior Policy: The state mileage rate was $.45.

New Policy: Effective 9/1/13 the state mileage rate increases to $.52 per mile.

Action Required: Individuals with self-employment deductions for mileage and consumers who utilize mileage expenses in their spend-down, blind work expense (BWE) or impairment-related work expense (IRWE) calculations are affected by this change. There is no desk review required.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

MEM Instructions:

<table>
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<tr>
<th>Location</th>
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http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 80 (Medicaid: Treatment of Stepparent and Grandparent Income for CFC Medicaid)

Medicaid Eligibility Procedure Letter No. 80

June 28, 2013

Effective Date: July 1, 2013

OAC Rules: 5101:1-40-20

TO: All Medicaid Eligibility Manual Holders

FROM: John B. McCarthy, Director

SUBJECT: Medicaid: Treatment of Stepparent and Grandparent Income for CFC Medicaid

Reason for Change: Federal regulation 42 CFR 435.113 prohibits a stepparent’s or grandparent’s income to cause ineligibility for CFC Medicaid eligibility for a stepchild or grandchild, respectively.

Prior Policy: Income allocated from a stepparent or grandparent is used in the eligibility determination of stepchildren and grandchildren, respectively.

New Policy: A stepparent’s or grandparent’s income shall not negatively impact CFC Medicaid eligibility for a stepchild or grandchild, respectively.

Action Required: For any stepchild or grandchild who fails low-income families or healthy start Medicaid eligibility due to a stepparent’s or grandparent’s income, the administrative agency shall complete a manual budget to determine financial eligibility and, if appropriate, fiat the category of assistance to pass, then approve Medicaid. A desk review is not required.

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

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http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 73 (Medicaid: JFS 03517 Healthchek Services Implementation Plan)

Medicaid Eligibility Procedure Letter No. 73

July 25, 2013

Effective Date: 07/01/13

OAC Rules: 5101:1-38-05

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director
Office of Medical Assistance

Subject: Medicaid: JFS 03517 Healthchek Services Implementation Plan

Reason for Change:

The Local Program Management Description (LPMD) has been reformatted as the JFS 03517 Healthchek Services Implementation Plan (HSIP). The intent of the JFS 03517 is to provide a form through which county agencies report the administration of Healthchek (EPSDT) services in their county. The LPMD was a suggested format. The JFS 03517 will replace the LPMD as the official form and will be the required format for submission. The HSIP is referenced in and required by OAC 5101:1-38-05. The form number is not specifically referenced.

No new policy or policy change will result from the implementation of this form.

Prior Policy: The CDJFS completed the LPMD to report the administration of Healthchek (EPSDT) Services in their county. The LPMD was a suggested format.

New Policy: If the CDJFS needs to submit a new or updated Healthchek (EPSDT) Services report, they will need to complete the JFS 03517 Healthchek Services Implementation Plan (HSIP). Agencies must discontinue use of the LPMD suggested format.

Action Required:

When updating an LPMD on file with OMA, the CDJFS is now required to submit changes to the Healthchek portion of the document via the HSIP form.

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MEPL 68 (Medicaid: Life Estate Valuation Table)

Medicaid Eligibility Procedure Letter No. 68

November 1, 2012

Effective Date:     October 15, 2012


To:          All Medicaid Eligibility Manual Holders
From:  John B. McCarthy, Director
Subject:  Medicaid: Life Estate Valuation Table

Reason for Change: Clarification of policy is needed, because rule 5101:1-39-32(F) directs workers to an incorrect table for the valuation of life estates. The CRIS-E system is programmed correctly, however, and has been using the correct table. This MEPL simply serves to clarify existing policy and practice.

Prior Policy: The rule directs workers to use the table found in 26 C.F.R 20.2031-7, which is an incorrect reference that does not have the correct table.

New Policy: This is not a policy change; it is simply clarification of an incorrect table reference. The following table, which CMS provided as guidance in the State Medicaid Manual, is the correct table:

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**Action Required:** No desk review is required, because CRIS-E has been using the correct table when calculating the value of life estates.

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MEPL 66 (Medicaid: Exclusion of VA Aid and Attendance Pensions in Patient Liability Calculations for HCBS Waiver Cases)

Medicaid Eligibility Procedure Letter No. 66

October 4, 2012

Effective Date: October 1, 2012


To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: Exclusion of VA Aid and Attendance Pensions in Patient Liability Calculations for HCBS Waiver Cases

Reason for Change: The court order ending the Ledford v. Colbert lawsuit requires ODJFS to change the way veterans' Aid and Attendance pension income is treated when calculating patient liability for HCBS waiver cases.

The Aid and Attendance pension is an enhanced or special monthly pension benefit that the Veterans Administration (VA) pays in addition to the basic pension. The VA pays Aid and Attendance to a veteran who needs assistance with activities of daily living, is bedridden, is a patient in a nursing home, or is blind, or is paid to the veteran's surviving spouse who meets the same criteria. When such a veteran who has no spouse or dependent minor or disabled child is institutionalized in a nursing facility, the VA reduces the individual's total pension to ninety dollars.

Prior Policy: The VA Aid and Attendance pension was treated differently for veterans in a nursing facility versus veterans receiving HCBS waiver services.

The VA Aid and Attendance pension was considered countable income in patient liability calculations for veterans who were receiving HCBS waiver services.

The VA Aid and Attendance ninety-dollar reduced pension paid to veterans in a Title XIX nursing facility was excluded as income in patient liability calculations. This part of the policy is not changing.

New Policy: As of the effective date of this letter, the first ninety dollars of VA Aid and Attendance pension is to be excluded as income in patient liability calculations for veterans or their widows who are receiving HCBS waiver services and who have no dependent minor or disabled children.

The VA Aid and Attendance ninety-dollar reduced pension paid to a veteran in a Title XIX nursing facility will continue to be excluded as income in patient liability calculations.

Action Required: No desk review is required. For new applications and redeterminations, beginning on the effective date of this letter, workers will need to perform the following steps in order to correctly determine patient liability:

- Enter the full amount of Aid and Attendance income on AEFMI, using TYPE “VA” with no subtype. This will ensure the Food Assistance budget is accurate.
- Calculate the patient liability manually.
- Perform AEWIF and AEWFT fiats to ensure that the first ninety dollars of Aid and Attendance pension income is excluded as income in the patient liability calculation.

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Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 65 (Medicaid: Changes to Disability Determination Process)

Medicaid Eligibility Procedure Letter No. 65

June 29, 2012

Effective Date: July 1, 2012


To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Changes to Disability Determination Process

Reason for Change: The Ohio Department of Job and Family Services, Office of Ohio Health Plans (OHP), has contracted with Ohio Employee Health Partnership (OEHP) to assist the County Departments of Job and Family Services (CDJFS) in developing the medical evidence needed to make a medical decision for those Medicaid applicants who have alleged a disability.

Prior Policy: Medical evidence for disability applications was gathered and submitted to the state disability determinations area (DDA) by CDJFS workers via the eQuIL system.

New Policy: OEHP will assist CDJFS offices statewide with the disability determination process by:

- Gathering medical evidence
- Ensuring that the examining physician or psychologist completes the JFS 07302 and/or JFS 07308 forms
- Deferring cases for additional information during the process of gathering medical documentation
- Scheduling medical and psychological testing and examinations when needed
- Assisting applicants with transportation when needed
- Uploading the medical evidence and additional eQuIL forms to eQuIL
- Building the case and uploading to eQuIL within 65 days from date of application
- Maintaining a toll free customer service phone number
- Maintaining a GroupWise email box for communication with the CDJFS and DDA
- Assisting the CDJFS with the gathering of medical documentation for hearing compliance

All new or Continuing Disability Review (CDR) cases with a date of application (or date of review) on or after the "go live" date of the OEHP contract will be developed by OEHP. The CDJFS will submit administrative information regarding each case to OEHP to initiate case development. For any disability case that is being developed by OEHP, if the CDJFS receives any medical documentation pertaining to that case, it should be forwarded to OEHP.

New or CDR cases which have a date of application (or date of review) prior to the "go live" date will be developed by the CDJFS following the processes that were in effect prior to the existence of the new contract.

Action Required: Details of the new disability determination process for various types of cases are as follows:

For new disability applications, the CDJFS shall immediately:

- Have the applicant sign several medical release forms (JFS 03397). Contact information for OEHP will be listed on the medical release forms so that the requested medical records will go directly to OEHP.
- Have the applicant sign an authorized representative form (JFS 06723) if needed
If the applicant presents for a face-to-face interview, the CDJFS may give the applicant a JFS 07302 and/or a JFS 07308, as appropriate, to take to his or her provider.

Complete and print a JFS 03605 e-form and a JFS 07004 e-form in eQuIL

- Include in the county comments section of the JFS 03605 a phone number (if available) for the applicant

Create CRIS-E screen AEICM.

Submit the JFS 03605 and the JFS 07004 e-forms to eQuIL.

Finish submission of the case by using one of the following methods:

- Fax to OEHP the following:
  - Copies of completed forms JFS 03605 and JFS 07004
  - Signed medical releases
  - Signed authorized representative form
  - Any medical documentation the county may have received

- Upload the following to eQuIL as a 3605A:
  - Signed medical releases
  - Authorized representative form
  - Any medical documentation the county may have received

Then email OEHP with the applicant's name, type of case and recipient ID

- Advise the applicant or the authorized representative that an OEHP representative will be assisting in gathering the medical evidence for their disability case and may be contacting them by phone or mail.

For CDR cases, the CDJFS shall:

- Complete and print a JFS 03605 form. DO NOT SUBMIT THIS FORM TO eQuIL. In the county comments section, include:
  - The term "CDR"
  - A phone number (if available) for the applicant
  - Previous approval dates
  - Previous approval code

- Complete and print an updated JFS 07004 form. DO NOT SUBMIT THIS FORM TO eQuIL. Include recipient information and complete sections I thru V

- Create an AEICM screen for the CDR case.

- Obtain several newly-signed JFS 03397 forms from the consumer.

- Fax to OEHP the following:
  - Copies of completed forms JFS 03605 and JFS 07004
  - Signed medical releases
  - Signed authorized representative form
  - Any medical documentation the county may have received

For AEMA or death cases, the CDJFS shall:
Create and print a JFS 03605 e-form in eQuIL. Include in the county comments section the following information:
- Proper case type
- Onset and end dates or date of death (as applicable)
- Name, address and phone number for the provider(s) who cared for the applicant during the time period requested

Submit the JFS 03605 e-form to eQuIL
Create an AEICM screen.
Finish submission of the case by using one of the following methods:
  a. Fax to OEHP the following:
     - Copy of the completed JFS 03605 e-form
     - Signed medical releases
     - Signed authorized representative form
     - Any medical documentation the county may have received
  or
  b. Upload the following to eQuIL as a 3605A:
     - Signed medical releases
     - Authorized representative form
     - Any medical documentation the county may have received

Then email OEHP with the applicant's name, type of case and recipient ID

For hearing compliance, the CDJFS shall:
- Complete and print a JFS 3605 form. DO NOT SUBMIT THIS FORM TO eQuIL. In the county comments section, include:
  - The term "Hearing compliance"
  - The term "Please notify county case worker when hearing compliance medical documentation has been received"
  - A phone number (if available) for the applicant
- Complete and print an updated JFS 07004 to identify the disability and the providers of care. DO NOT SUBMIT THIS FORM TO eQuIL.
- Create an AEICM for the state hearing case.
- Obtain several newly-signed JFS 03397 forms from the consumer.
- Fax to OEHP the following:
  - Copies of completed forms JFS 03605 and JFS 07004
  - Signed medical releases
  - Signed authorized representative form
  - Hearing decision
  - Any medical documentation the county may have received
- Once OEHP notifies the CDJFS that the medical evidence has been obtained, the CDJFS will notify the DDA developer who will then guide both OEHP and the CDJFS in eQuIL upload instructions.

After the disability application is initiated:
- The CDJFS will be available during the course of the disability review process to collaborate, communicate or respond to OEHP as needed for assistance while OEHP is developing the case and gathering the medical evidence that relates to the alleged disability.
- OEHP will upload completed disability packets to eQuIL.
- When a completed disability packet is uploaded by OEHP to eQuIL, eQuIL will alert the active CRIS-E screen AEICM.
- When the medical review of the case has been completed in eQuIL and a decision has been made in eQuIL, eQuIL will alert the active CRIS-E screen AEICM.

**Important facts:**
- County disability case workers should continue to monitor the county DDU email box as it will be used by OEHP for communication between counties, OEHP and the DDA.
- The county's role in state hearings will remain as is.
- The developers' role in state hearings will remain as is.
- If the CDJFS closes the Medicaid case while OEHP is developing the disability case, the CDJFS will notify both OEHP and the DDA by email of the closure and request for withdrawal from eQuIL.
- Initially, submission of documents to OEHP will be via fax; eventually, submission will be via electronic means yet to be determined.

**OEHP contact information:**
- Toll free customer service phone number: 1-855-455-4755
- Toll free fax number: 1-855-455-4955 (documents must have recipient ID noted)
- GroupWise email address: OEHP_DDU@jfs.ohio.gov
- Mailing address: OEHP-DES, 333 South Street, Shrewsbury, MA 01545

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MEPL 58 (Medicaid: Deeming Calculator)

Medicaid Eligibility Procedure Letter No. 58

September 13, 2011

Effective Date: September 12, 2011


To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Deeming Calculator

Reason for change: Currently, CRIS-E is not programmed to properly calculate budgets in Aged, Blind, or Disabled (ABD) Medicaid cases where there is spouse-to-spouse or parent-to-child deeming. A deeming calculator has been developed to calculate deeming budgets properly based upon Social Security's Program Operations Manual System (POMS).

Prior Policy: ABD Medicaid budget calculations for deeming of income were completed in the CRIS-E system.

New Policy: Use the deeming calculator when completing ABD Medicaid budgets with deeming of income from spouse-to-spouse, and deeming of income from parent-to-child (including step parent). The deeming calculator has four tabs at the bottom: spouse to spouse; parent to child; income exclusions; and data inputs. The income exclusions tab includes links to the appropriate POMS section for each exclusion listed. The data inputs tab lists the appropriate SSI payment standards for individuals and couples for 2010 and 2011; future years will be updated as needed.

Action Required:

Utilize the deeming calculator, available on the County Resources web page, to calculate spouse-to-spouse and parent-to-child deeming budgets for ABD Medicaid. Print a screen shot of the appropriate completed budget calculation for the case report. Workers will need to flat cases for correct eligibility issuance.

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MEPL 56 (Medicaid: MIA for Waiver Consumers with Institutionalized Spouses)

Medicaid Eligibility Procedure Letter No. 56

August 22, 2011

Effective Date: August 1, 2011


To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Monthly Income Allowance (MIA) for Waiver Consumers with Institutionalized Spouses

Reason for Change: Clarification of rules regarding MIA from institutionalized spouse to community spouse receiving waiver services.

Prior Policy: Previously considered the community spouse receiving waiver services as an institutionalized spouse when determining MIA.

New Policy: Community spouse receiving waiver services continues to live in the community and may need the MIA to meet monthly living expenses in the community. The MIA from an institutionalized individual to the community spouse who is waiver-eligible is treated as unearned income in the determination of medical assistance and patient liability per Ohio Administrative Code 5101:1-39-24(C)(2)(d)(viii).

Action Required: Explore eligibility for a MIA when an Institutionalized Spouse has a spouse in the community receiving Waiver services. Treat the MIA as unearned income in the determination of medical assistance and patient liability.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

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MEPL 54 (Medicaid: Resources for Children Ages 19 and 20)

Medicaid Eligibility Procedure Letter No. 54

April 8, 2011

Effective Date: April 1, 2011


To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Resources for Children Ages 19 and 20

Reason for Change: To comply with the performance bonus requirements of the Children's Health Insurance Program Reauthorization Act of 2009, Ohio must remove the resource limit for children ages 19 and 20 who do not receive Medicaid for persons with blindness or Medicaid for persons with disabilities. This covered group is known as "Ribicoff children".

Prior Policy: To qualify for Medicaid, the Ribicoff child shall have family resources of no more than $1,000 and shall meet all other Medicaid conditions of eligibility.

New Policy: To qualify for Medicaid, the Ribicoff child shall no longer have family resources considered for Medicaid eligibility purposes and shall meet all other Medicaid conditions of eligibility.

Action Required: The administrative agency shall not require verification of resources nor impose a resource limit towards any Ribicoff child, known as CRIS-E category MA-T. For any Ribicoff child, the administrative agency shall not complete any resource screens in CRISE, which are any following the AERRQ screen. For any Ribicoff child who does fail in CRISE for reason codes 328, 329, or 386, the administrative agency shall flat the MA-T to pass, in accordance with rules 5101:1-38-01.2 and 5101:1-38-01.8 of the Administrative Code.

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MEPL 51 (Medicaid: Puerto Rican Birth Certificates)

Medicaid Eligibility Procedure Letter No. 51

November 19, 2010

Effective Date: November 1, 2010

OAC Rules: 5101:1-38-02

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Puerto Rican Birth Certificates

Reason for Change: The Commonwealth of Puerto Rico has issued new regulation that, as of November 1, 2010, effectively invalidates all birth certificates issued by Puerto Rico before July 1, 2010. New birth certificates may be requested by individuals born in Puerto Rico. While an individual must pay a $5.00 fee to receive a new birth certificate, a CDJFS may receive an electronic transcript of the birth certificate free of charge for official purposes.

Prior Policy: As set out in MEPL 45, effective April 22, 2010, a data exchange with the Social Security Administration (SSA) is the primary verification source for U.S. citizenship. If citizenship cannot be verified through this data match, the CDJFS shall make a reasonable effort to identify and resolve the inconsistency, including correcting any identified errors and resubmitting the request for verification.

If all other eligibility factors have been met except the citizenship verification, the CDJFS shall approve the individual for medical assistance, send a notice to the individual, and allow the individual 90 days from the date of the notice to provide satisfactory documentation of citizenship or to assist the CDJFS in resolving the inconsistency with SSA's information.

If, at the end of this 90-day reasonable opportunity period, the inconsistency has not been resolved and evidence of citizenship or nationality has not been provided, the CDJFS must propose termination of Medicaid coverage within 30 days.

During this reasonable opportunity period, there is no distinction in verification methods between individuals born in Puerto Rico and individuals born elsewhere in the United States or its territories.

New Policy: If an individual applies for medical assistance for the first time on or after November 1, 2010, the SSA data exchange is still the primary verification source for U.S. citizenship for all applicants. If citizenship cannot be verified through this data match, the CDJFS shall make a reasonable effort to identify and resolve the inconsistency, including correcting any identified errors and resubmitting the request for verification.

As before, if all other eligibility factors have been met except the citizenship verification, the CDJFS shall approve the individual for medical assistance, send a notice to the individual, and allow the individual a 90-day reasonable opportunity period. However, a birth certificate issued by Puerto Rico is an acceptable citizenship verification document only if the birth certificate was issued after July 1, 2010.

Action Required:

If an individual has previously applied for medical assistance and citizenship has been verified as required by rule 5101:1-38-02 of the Administrative Code, no further action is required.

When an initial application for medical assistance is received, the CDJFS shall continue to use the data exchange with the Social Security Administration (SSA) as the primary verification source for U.S. citizenship.

For all applications for medical assistance dated on or after November 1, 2010, the CDJFS shall accept a birth certificate issued by Puerto Rico as a citizenship verification document only if it was issued after July 1, 2010.

If a consumer born in Puerto Rico does not have a birth certificate issued on or after July 1, 2010, or other acceptable citizenship verification documentation, the CDJFS shall request validation of the data on the individual's invalid (pre-July 1, 2010 birth certificate). The request for validation must include the individual's:
1. Name as it appears on the birth certificate (including all last names if more than one last name is listed); and
2. Date of birth; and
3. Place of birth.

The request must also include an official government email address, fax number, or mailing address to which the response should be sent.

All requests must be made in writing by e-mail, fax, or mail. Requests may be emailed to Registrodemografico@salud.gov.pr from an official government email address. A request on official CDJFS letterhead may be faxed to the attention of the Validation Office at 1 (787) 767-8605 or 1 (787) 766-1299, or mailed to:

Validation Office
Demographic Registry Office of Puerto Rico
Department of Health
P.O. Box 11854
San Juan, Puerto Rico 00910

Within two days, at no cost, the Validation Office will either validate (confirm) the provided demographic information or inform the CDJFS that the submitted information is not consistent with information held by their office. All validations will include an official stamp from the Validation Office.

If the information on the individual's birth certificate is validated, the birth certificate (combined with the validation) may be used as verification of the individual's citizenship. If the information is inconsistent, the CDJFS shall work with the individual to determine the cause of the inconsistency or to find other citizenship verification.

Note: Information received from the Validation Office is privileged and confidential. Any unauthorized dissemination, distribution or copies is prohibited.

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MEPL 49 (Medicaid: Part D $250.00 Rebate)

Medicaid Eligibility Procedure Letter No. 49

July 12, 2010

Effective Date: July 1, 2010


To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Closing the Medicare Prescription Drug "Donut Hole", Medicare Part D Rebate for 2010

Reason for Change: The Patient Protection and Affordable Care Act, along with the Reconciliation Act, collectively known as the Affordable Care Act provide qualifying individuals with a $250 rebate to close the Medicare Prescription Drug "Donut Hole".

The individual who has incurred covered Part D prescription drug costs that cause the individual to exceed the initial coverage limit within any calendar quarter in 2010 will be eligible for the rebate. Payment of the rebate will be provided from the Federal Medicare Prescription Drug Account no later than the 15th day of the third month following the end of such quarter. The rebate is limited to only one payment per individual.

Prior Policy: 5101:1-39-18 of the Administrative Code states any cash provided by a governmental medical or social services program is not income. Reimbursements for medical or social services already received that are not in excess of the medical or social services expenses are not considered income.

New Policy: The new $250 Part D Prescription Drug one time rebate is considered a payment from a governmental program for medical or social service purposes as described in 5101:1-39-18 of the Administrative Code. It is not considered income, and is exempt for Medicaid purposes. The rebate is considered a countable resource the month after the month of receipt pursuant to 20 C.F.R. 416.1201(a)(3).

Action Required: The CDJFS shall consider the one time $250 rebate for the Part D Prescription Drug Program as exempt income as described in 5101:1-39-18(B)(10) of the Administrative Code. The rebate is considered a countable resource the month after the month of receipt pursuant to 20 C.F.R. 416.1201(a)(3).

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MEPL 47 (BCCP Form JFS 07160 Revision)
Medicaid Eligibility Procedure Letter No. 47

June 1, 2010

OAC Rule: 5101:1-41-05
To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: BCCP Form JFS 07160 Revision

Forms
JFS 07160 (rev. 05/2010) "Healthcare Provider's Revision of Treatment Plan"

The changes to the Breast and Cervical Cancer Project form JFS 07160 (rev. 05/2010) "Healthcare Provider's Revision of Treatment Plan" are a result of the elimination of the treatment plan from the application JFS 07161 (09/2009). The form JFS 7160 has been modified to assist the Ohio Department of Health with the BCCP review and to assist ODJFS with the pre-termination review process. Form JFS 07160 will be a stand alone form. Changes to the form include:

- Removing the "invasive cancer" from the Cervical Terms for Blue Diagnostics Sheet.
- Removing the "invasive cancer" from the Breast Terms from Pink Diagnostics Sheet.
- Incorporating Pre-Termination Review (PTR) questions on the bottom of the form.

The effective date for use of the form is June 1, 2010.

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MEPL 46 (eGateway/"Model" Applications)

Medicaid Eligibility Procedure Letter No. 46

May 19, 2010

Effective Date: June 1, 2010

OAC Rule: 5101:1-38-01, 5101:1-38-01.2

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: eGateway and "Model" Applications

eGateway Applications for Medicare Premium Assistance Programs

As a result of the Medicare Improvements for Patients and Providers Act of 2008, when an individual submits an application to the Social Security Administration (SSA) for the Medicare Part D Low-Income Subsidy (also known as "Extra Help"), that application is electronically sent on to ODJFS as an application for medical assistance unless the individual specifies otherwise.

Unless the consumer is currently receiving medical assistance, this application information is passed on to county workers through the eGateway system. These electronic data elements, which can be identified by the code "SS" in the source field, shall be treated as a signed and dated form JFS 07103.

Federal law requires these applications, received by county workers through the eGateway system, be treated as a signed and dated application for Ohio Medicaid. Like other applications already received through the eGateway, eligibility determinations must be made within the application timeliness period.

All responsibilities under rules 5101:1-38-01 "Medicaid: Individual and Administrative Agency Responsibilities" and 5101:1-38-01.2 "Medicaid: Application, Determination, and Redetermination Processes", including the responsibility to determine eligibility in a timely manner, are triggered by receipt of applications in eGateway.

"Model" Applications

The Centers for Medicare and Medicaid Services (CMS) has published a "Medicare Savings Programs (MSP) Model Application" on their website. Although this is not an official application (it was intended as a model that states could use), some consumers may fill out this form and turn it in to county agencies. This is not an ODJFS application, and the signature block does not contain some of the necessary recognitions.

Receipt of any "model application" or non-ODJFS application should be treated as a request for an application. The consumer should be given or mailed an ODJFS application (and all accompanying forms) and advised that the ODJFS application must be signed and dated, and that the application must be reviewed and non-duplicated information must be provided. The model application can then be attached to the signed ODJFS application.

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MEPL 45 (Medicaid: Reasonable Opportunity to Provide Documentary Proof of Citizenship)

Medicaid Eligibility Procedure Letter No. 45

April 22, 2010

Effective Date: April 22, 2010

OAC Rule: 5101:1-38-01.8, 5101:1-38-02

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Reasonable Opportunity to Provide Documentary Proof of Citizenship

Reason for Change: Section 211 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, includes provisions modifying the Medicaid requirement for documentation of citizenship, including a new option to assist States in meeting this requirement.


New Policy: Individuals who declare they are U.S. citizens or nationals shall be provided a reasonable opportunity to present satisfactory documentation of citizenship. The individual(s) shall be enrolled in Medicaid pending the reasonable opportunity to document the claim, assuming all other eligibility factors have been met.

Data exchange with the Social Security Administration (SSA) shall be used as the primary verification source for U.S. citizenship.

Action Required: Effective April 22, 2010, individuals applying for Medicaid shall be given reasonable opportunity to provide verification of U.S. citizenship. Reasonable opportunity shall not exceed application processing time limits set forth in rule 5101:1-38-01.2 of the Administrative Code.

The County Department of Job and Family Services (CDJFS) shall not deny, delay, reduce or terminate Medicaid eligibility during the reasonable opportunity period. Once an individual has declared U.S. citizenship and has provided all information and verifications needed to determine eligibility, the CDJFS shall make the eligibility determination. The CDJFS shall authorize Medicaid benefits for the individual while the documents needed to satisfy the citizenship documentation requirement are being secured.

Beginning April 22, 2010, an online process using SVRQ will be available to request U.S. citizenship information from SSA. If the CDJFS receives notice through SVRQ that the individual’s name, date of birth, social security number or declaration of citizenship or nationality is inconsistent with information in the SSA’s records, or if no match is found, the CDJFS shall make a reasonable effort to identify and resolve the inconsistency. If an error is identified, the CDJFS must correct and resubmit the request.

If the inconsistency is not resolved within the reasonable opportunity period, the CDJFS shall send a notice to the individual and allow the individual within 90 days from the date of the notice to provide satisfactory documentation of citizenship/nationality or the individual must assist the CDJFS in resolving the inconsistency with SSA’s information. The 90 day period is considered the reasonable effort period. During this 90 day period, the individual remains enrolled in Medicaid assuming all other eligibility factors have been met. If after 90 days the inconsistency is not resolved, and evidence of citizenship or nationality has not been provided, the CDJFS must propose termination within 30 days.

A CRIS-E View Flash Bulletin (CLVB) will be issued with information contained in this MEPL.

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MEPL 44 (Medicaid: JFS 07216 Revision)

Medicaid Eligibility Procedure Letter No. 44

April 1, 2010

Effective Date: April 1, 2010

OAC Rules: 5101:1-38-01.2

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: JFS 07216 Revision

Forms

JFS 07216 "Combined Programs Application"

This form has been revised to make the following changes requested by the Ohio Department of Health (ODH).

- Section C has been revised to clarify that retroactive coverage is only available when applying for Medicaid, and that there is no need to submit retroactive medical bills to ODH.

- On page 3, language has been changed to clarify that additional household members should be listed on another sheet of paper. Language has been revised to state that an individual's Social Security Number and proof of U.S. citizenship or alien status are only required when applying for Medicaid.

- On page 4, descriptions have been updated for Women, Infants, & Children (WIC); Child and Family Health Services (CFHS); and Help Me Grow (HMG).

- In order to clarify the distinction between the ODJFS-administered Medicaid program and the ODH-operated programs, the term "health coverage" is no longer used when discussing only the Medicaid program. Instead, either "Healthy Start and Healthy Families" or "Medicaid" are used to refer to these specific programs, while "health coverage" is used more broadly to discuss the various programs.

Form JFS 07216 is available from ODJFS Forms Central.

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MEPL 43 (Medicaid: Updates to Deemed Newborn Eligibility)

Medicaid Eligibility Procedure Letter No. 43

April 8, 2010

Effective Date: April 1, 2010


To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Updates to Deemed Newborn Eligibility

Reason for Change: Section 211 of The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, includes several provisions that are designed to ensure immediate coverage for newborn children born to mothers who are enrolled in Medicaid.

Prior Policy: A child enrolled as a deemed newborn was required to provide documentation of U.S. citizenship at the point of Medicaid eligibility redetermination when the child turned one year old.

Deemed Medicaid newborns were required to reside with the mother, remain a member of the mother’s household and the mother remain eligible for Medicaid or would remain eligible if still pregnant.

New Policy: By virtue of being born in the United States, individuals initially eligible for Medicaid as deemed newborns automatically meet the U.S. citizenship requirement for Medicaid purposes.

CHIPRA eliminates previous requirements for deemed newborn Medicaid eligibility that the newborn must come home from the hospital to live with the mother, remain a member of the mother’s household, and that the mother remain eligible for Medicaid or would remain eligible if still pregnant.

Action Required: Beginning 4/1/10, the County Department of Job and Family Services (CDJFS) shall no longer require documentation of U.S. citizenship for any newborn children born to mothers who are enrolled in Medicaid. Deemed newborns are not required to further document citizenship at any subsequent Medicaid eligibility determination or redetermination.

In addition, the CDJFS shall no longer require deemed newborns to return home to live with the mother, remain a member of the mother’s household, and that the mother remain eligible for Medicaid or would remain eligible if still pregnant.

The CRIS-E table TMCV will be updated at a later date to support the citizenship change, and a CLVB will be sent at that time. A CRIS-E View Flash Bulletin (CLVB) will be issued with information contained in this MEPL.

MEM Instructions:

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This information is also available on the Internet and may be accessed at:

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Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 42 (JFS 02453 "Inpatient Hospital Admission" Form)
Medicaid Eligibility Procedure Letter No. 42

December 16, 2009

Effective Date: January 1, 2010

OAC Rules: 5101:1-38-01 and 5101:1-38-01.2

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: JFS 02453 "Inpatient Hospital Admission" Form

Reason for Change: JFS 02453 is obsolete.

Prior Policy: The JFS 02453 served four primary purposes: 1) As an intent to file for Medicaid pending the individual submitting an application. 2) As a report of birth for a newborn from the hospital to the CDJFS. 3) As an identity document in verifying U.S. citizenship. 4) As a method to report billing numbers to hospitals.

New Policy: 1) Individuals wishing to receive Medicaid shall apply using a Medicaid application. Federal regulation requires an application be completed in order to have eligibility determined. 2) Newborns born to Medicaid eligible women shall be reported by the individual or someone acting on the individual's behalf. Currently, MCP's provide lists to the CDJFS of births to women enrolled in their plan. 3) New legislation in the American Recovery and Reinvestment Act of 2009 (ARRA) allows newborns born to Medicaid eligible women to automatically meet the identity requirement for U.S. citizenship. 4.) Hospitals shall verify billing number and provider information through the Interactive Voice Response System (IVR).

Action Required: CRISE screens and references to the JFS 02453 will be removed from the system at a later date. The CDJFS shall discard its supply of the form. The CDJFS shall continue, however, to process any remaining JFS 02453s received on or after January 1, 2010 to add newborns. The CDJFS shall inform hospitals to verify client eligibility and provider information through IVR at 1-800-686-1516 or the web portal at https://medicaidremit.ohio.gov.

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MEPL 40 (Medicaid: Making Work Pay Credit)

Medicaid Eligibility Procedure Letter No. 40

November 13, 2009

Effective Date: 12/1/09


To: All Medicaid Eligibility Manual Holders

From: Douglas Lumpkin, Director

Subject: Medicaid: Making Work Pay Credit (MWPC) under the American Recovery and Reinvestment Act 2009 (ARRA)

Reason for Change: Division B, Title I, Section 1001 of the American Recovery and Reinvestment Act (ARRA) provides qualifying individuals an income tax credit, known as the Making Work Pay Credit (MWPC). The credit is issued through changes to automated withholding amounts or through a credit claimed on tax returns. The credit is in effect for calendar years 2009 and 2010.

For individuals earning less than $75,000 per year, the maximum credit per year is the lower of 6.2 percent of the individual's earned income or $400. For individuals earning more than $75,000 per year, the work credit is reduced by 2 percent.

ARRA prohibits the Medicaid program from treating the MWPC as income and provides guidance regarding counting it as a resource.

Prior Policy: All non-exempt earned income and unearned income is considered in Medicaid eligibility budgeting as described in rules 5101:1-39-20 and 5101:1-40-20 of the Administrative Code. Certain payments an individual receives are considered income in the month of receipt and a countable resource in the month following the month of receipt.

New Policy: Beginning 12/1/09, the CDJFS shall not treat the MWPC as income in eligibility determinations or budgeting for any Medicaid program. To address this, certain consumers shall be given an MWPC income deduction.

Also, the CDJFS shall not treat MWPC as an available countable resource for any Medicaid program during the month of receipt and for two months after the month of receipt.

Action Required: For budgets run on or after the effective date of this MEPL, caseworkers will receive a message on AEFES for cases where eligibility is denied due to being over income by $34 or less per month (thirty-four dollars is the monthly pro-rated amount of the annual $400 MWPC).

In these cases, the caseworker will need to run the budget using the new "Making Work Pay Credit" calculator (located on the County Resource Web page) for each person who has earned income, in order to give each individual the pro-rated monthly MWPC deduction. http://innerweb/ohp/countyRes/

If the case is determined eligible using the MWPC deduction, the caseworker will need to complete a fiat to pass the AG for Medicaid, and document the eligibility and fiat in CLRC.

Table TFRC will be updated with the new Fiat reason code: IND/FAM MEDICAID ELIGIBLE DUE TO MWPC.
Table TERM will be updated with the new worker message: MEDICAID BUDGET-MWPC FIAT?

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

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http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 37 (Medicaid: Economic Recovery Payments under the American Recovery and Reinvestment Act 2009 [ARRA])

July 6, 2009

Medicaid Eligibility Procedure Letter No. 37

Effective Date: February 17, 2009


To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Economic Recovery Payments under the American Recovery and Reinvestment Act 2009 (ARRA)

Reason for change: Public Law No. 111-5 (the "American Recovery and Reinvestment Act of 2009") provides for a one-time payment of $250 to individuals who are eligible for benefits under Social Security, Supplemental Security Income, Railroad Retirement Benefits, and Veterans Disability Compensation or Pension Benefits. The one-time payments were issued throughout the month of May 2009 and no later than June 4, 2009.

Section 2201(c) of Public Law No. 111-5 specifies that the economic recovery payments received under the American Recovery and Reinvestment Act of 2009 are not considered income to the recipient, or to the recipient's spouse or family, when determining eligibility for Medicaid. The payments are also not considered a resource in the month of receipt and for nine months following the month of receipt to the recipient, or to the recipient's spouse or family, when determining eligibility for Medicaid.

Prior Policy: Certain payments an individual receives are considered income in the month of receipt and a countable resource in the month following the month of receipt.


These payments shall not be used to determine the amount of an individual's spenddown under rule 5101:1-39-10 "Medicaid: Eligibility Through the Spenddown Process" or determine a premium under 5101:1-41-30 "Medicaid: Medicaid Buy-In for Workers with Disabilities (MBIWD)". They should also not be used to calculate the amount of patient liability under rule 5101:1-39-24 "Medicaid: Determining Patient Liability" or 5101:1-39-24.1 "Medicaid: Income and Patient Liability Determinations for Individuals Under the Assisted Living Home and Community Based Waiver". Counting the payments as income under post-eligibility violates the maintenance of effort requirements of ARRA.

Many long-term care facility residents, individuals receiving payment through the Residential State Supplement Program, or individuals receiving services through the Program of All-Inclusive Care for the Elderly, Assisted Living Service Waiver, or Home and Community Based Services are eligible for the one-time payment. The payment can be used for the resident’s personal use and not to pay the facility for cost of care. Long-term care facilities receiving the payment directly on behalf of the resident shall not take the money toward the cost of care, but rather place the payment in the resident's personal needs account.

Additionally, in the month of receipt and for nine months following the month of receipt, these payments should not be considered an available or countable resource under rule 5101:1-39-05 "Medicaid: Resource Requirement", 5101:1-40-14 "Covered Families and Children (CFC) Medicaid: Resources: Application, Definitions, Availability, and Limitations", or 5101:1-41-30 "Medicaid: Medicaid Buy-In for Workers with Disabilities (MBIWD)".


An economic recovery payment shall not be counted in determining the amount or extent of benefits or assistance. Payments given away in part or whole during the month of receipt and the nine month exemption period are not considered transfers of assets for less than fair market value and not subject to transfer penalties. Payments placed in a trust during the month of receipt and the nine month exemption period shall not be subject to transfer penalties or counted under the Medicaid trust provisions.

**Action Required:** The CDJFS shall not treat the economic recovery payments under the American Recovery and Reinvestment Act of 2009 as income in eligibility determinations or budgeting for any Medicaid program.

The CDJFS shall not treat these payments as available or countable resources for any Medicaid program for nine months following the month of receipt. In the tenth month after the month of receipt, the CDJFS must determine resource eligibility for any Medicaid program without consideration of whether the resource is or was an economic recovery payment.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

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MEPL 36 (Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities)

June 11, 2009

Medicaid Eligibility Procedure Letter No. 36

Effective Date: July 1, 2009

OAC Rules: 5101:1-39-07 Medicaid: transfer of resources

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities

Reason for Change: The Ohio Department of Aging has provided an updated average private pay rate for nursing facilities. Effective July 1, 2009, the average monthly private pay rate is $6,023.

Prior Policy: The previous average private pay rate, last updated in 2007, was $5,247.

New Policy: The updated private pay rate for nursing facilities is $6,023.

Action Required: A new period of restricted coverage is not computed for individuals currently in a penalty period. The CDJFS is not required to re-compute an improper transfer penalty period unless there is new information regarding the improper transfer (e.g. the resource was returned to the individual). The original notice that was issued to the applicant/recipient is still valid.

For new periods of restricted coverage calculated on or after July 1, 2009, the CDJFS is required to use the updated average private pay rate to calculate the penalty period.

CRIS-E reference table TMEP has been updated to reflect this increase for recurring budgets effective July 1, 2009.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL.

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</table>

Medicaid Eligibility Policy Letter No. 3 is obsolete upon the effective date of this MEPL.

This MEPL is also available on the Internet and may be accessed at:

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Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 35A (Medicaid: Special Instructions for Treatment of Unemployment Compensation/FAC in MBIWD Premium Calculations)

June 11, 2009

Medicaid Eligibility Procedure Letter No. 35A

Effective Date: February 17, 2009

OAC Rules: 5101:1-41-30

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Special Instructions for Treatment of Unemployment Compensation/FAC in MBIWD Premium Calculations

Reason for change:

Section 2002(h) of the American Reinvestment and Recovery Act of 2009 (ARRA) states that the additional $25 in weekly unemployment income known as Federal Additional Compensation (FAC) is to be disregarded for all Medicaid purposes.

As previously announced in MEPL 35, code "UCFA" has been added to CRIS-E table TVIN, so that FAC income will be disregarded for Medicaid. It was recently discovered, however, that CRIS-E is using the FAC payment amounts as income when calculating MBIWD premiums.

Action Required:

Workers will need to perform the following work-around on screen AEMPS. First, review AEFMI to ensure the FAC income is entered and coded correctly. If the MBIWD-eligible individual is receiving FAC payments, enter the annualized amount of the FAC payments (that is, $1,284) in the "IND - ADJ" field on AEMPS. If the spouse of the MBIWD-eligible individual is receiving FAC payments, enter the annualized amount of the FAC payments in the "FAM - ADJ" field. After entering the amount in either or both fields, as applicable, use PF17 to recalculate the MBIWD premium, then complete the case processing as normal.

MEM Instructions:

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**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 35 (Medicaid: Treatment of Unemployment Income/FAC)
May 20, 2009

Medicaid Eligibility Procedure Letter No. 35
Effective Date: February 17, 2009


To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Treatment of Unemployment Income/FAC

Reason for change:
Section 2002(h) of the American Reinvestment and Recovery Act of 2009 (ARRA) permits states to give individuals receiving unemployment compensation (UC) an additional $25 in weekly unemployment income. Known as Federal Additional Compensation (FAC), the FAC payments will be issued separately from the regular weekly UC benefit.

The FAC must be disregarded for purposes of Medicaid and Healthy Start eligibility determinations.

The Office of Unemployment Compensation is scheduled to begin issuing FAC payments toward the end of April or the beginning of May. FAC will be paid retroactively to the week ending February 28, 2009, as stated in the ARRA legislation.

UC data will display in CRIS-E on screens DEUC and AEDUC. This information is updated weekly. UC data may be overlaid in situations where retroactive UC or FAC payments have been issued or recovered. CRIS-E only captures 52 lines of UC information; therefore, CRIS-E will now display only 26 weeks of information, instead of 52 weeks’ worth. Please note: The FAC payment will display as either $25 (pre-tax) or $22 (after tax), depending on the recipient’s stated preference.

On Table TVIN, code UCFA has been created to automatically disregard the weekly FAC payments for Medicaid and Healthy Start purposes.

Action Required:
The CDJFS must verify Medicaid consumers’ receipt of FAC by checking DEUC and/or AEDUC to view the payment history for individuals receiving unemployment compensation. FAC payments (including any lump sums paid) will be listed separately by week on those screens.

Because FAC is disregarded for purposes of Medicaid eligibility determination, the CDJFS must enter the monthly FAC amount on AEFMI separately from the regular UC benefit payment. Regardless whether the FAC displays as $25 or $22 on DEUC, the CDJFS must calculate the monthly FAC amount based on the $25 pre-tax figure. The monthly FAC benefit must be coded as "UCFA" on AEFMI.

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http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 27 (Iraqi and Afghan Special Immigrants)

April 14, 2008

Medicaid Eligibility Procedure Letter No. 27

Effective Date: December 26, 2007

OAC Rules: OAC 5101:1-38-02.3

To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Iraqi and Afghan Special Immigrants

Reason for Change: Section 525 of Title V of Division G (Public Law 110-161) and Section 1244(g) of the National Defense Authorization for Fiscal Year 2008, (P. L. 110-181) establish special immigrant status for Afghans and Iraqis and their families (spouse and unmarried children under 21) under Medicaid or Refugee Medical Assistance (RMA).

New Policy: Under this time-limited exemption, an Iraqi with special immigrant status can receive eight months of Medicaid from date of entry into the United States (US).

An Afghan special immigrant may receive Medicaid for six months from date of entry.

However, if an Iraqi or Afghan has his or her status adjusted to special immigrant status while in the US, the time limit begins on the date of adjustment of status.

An Iraqi or Afghan special immigrant must meet the requirements of Medicaid to be eligible. An individual who does not qualify for a Medicaid category may be potentially eligible for RMA (which is also limited to eight months for Iraqis or six months for Afghans).

No retroactive coverage is available prior to the effective date of the law, December 26, 2007.

A special immigrant may qualify for Alien Emergency Medical Assistance (AEMA), under certain circumstances, after the time-limited exemption expires.

Following the eight or six month eligibility period, Iraqi and Afghan special immigrants are treated as any other lawful permanent resident (LPR) and are subject to the 40-quarter requirement.

Action Required: The CDJFS shall process applications submitted by Iraqi and Afghan special immigrants, requiring verification of status and eligibility for Medicaid or RMA. Counties are required to manually track these special immigrants, from the date of entry into the U.S. or adjustment of status, to ensure receipt of benefits does not exceed the maximum time-limited period (six months from date of entry for Afghan special immigrants or eight months from date of entry for Iraqi special immigrants).

A CRIS-E view flash bulletin (CLVB) is issued with the information contained in this MEPL. Information about verifying these special immigrants’ status and CRIS-E instructions can be found in FACT No. 30 and ACT No. 245 letters located in eManuals.

MEM Instructions:

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MEPL 26 (Medicaid: Tax Refunds under the Economic Stimulus Act of 2008)
April 14, 2008

Medicaid Eligibility Procedure Letter No. 26

Effective Date: February 13, 2008


To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Tax Refunds under the Economic Stimulus Act of 2008

Reason for Change: Public Law No. 110-185 (the "Economic Stimulus Act of 2008") calls for tax credits or refunds ranging between $300 and $600 per eligible individual, with an additional $300 per qualifying child. These credits or refunds will be made beginning in May, 2008.

Section 101(d) of Public Law No. 110-185 specifies that tax credits or refunds advanced under the Economic Stimulus Act of 2008 are not considered income to the recipient; these tax credits or refunds are also not considered a resource in the month of receipt or the following two months.


These tax credits or refunds should not be used to determine the amount of an individual's spenddown under rule 5101:1-39-10, "Medicaid: Eligibility Through the Spenddown Process" or to determine a premium under 5101:1-41-30 "Medicaid: Medicaid buy-in for workers with disabilities (MBIWD)". They should also not be used to determine the amount of patient liability under rule 5101:1-39-24 "Medicaid: Determining Patient Liability" or 5101:1-39-24.1 "Medicaid: Income and Patient Liability Determinations for Individuals Under the Assisted Living Home and Community Based Waiver".

Additionally, in the month of receipt and for two months following the month of receipt, these tax credits or refunds should not be considered an available or countable resource under rule 5101:1-39-05 "Medicaid: Resource Requirement", 5101:1-40-14 "Covered Families and Children (CFC) Medicaid: Resources: Application, Definitions, Availability, and Limitations", or 5101:1-41-30 "Medicaid: Medicaid Buy-In for Workers with Disabilities (MBIWD)".

Action Required: The CDJFS must not treat tax credits or refunds paid under the Economic Stimulus Act of 2008 as income in eligibility determinations or budgeting for any Medicaid program.

In the month of receipt, and for the following two months, the CDJFS must not treat these tax credits or refunds as available or countable resources for any Medicaid program. In the third month after the month of receipt, the CDJFS must determine resource eligibility for any Medicaid program without consideration of whether the resource is or was a tax credit or refund.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

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Reason for Change: With the passage of Amended Substitute House Bill (HB) 119, the Residential State Supplement (RSS) Program payments will increase beginning July 2007.

New Policy: The financial need standard for the Residential State Supplement Program is increased effective July 1, 2007. The financial need standard is used to determine whether a resident is eligible for a RSS payment and the amount each resident receives per month. The amounts provided under Am. Sub. H.B. 119 represent a 3% increase.

This information can be found in CRISE in table TOSS. The increased amounts for 2007 are in bold print below.

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<th>Living Arrangement Type</th>
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<td>$1854</td>
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<tr>
<td></td>
<td>($900 2006)</td>
<td>($1800 2006)</td>
</tr>
<tr>
<td>Resident of an adult group home</td>
<td>$927</td>
<td>$1854</td>
</tr>
<tr>
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<td>($900 2006)</td>
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</tr>
<tr>
<td>Resident of an adult foster home</td>
<td>$824</td>
<td>$1648</td>
</tr>
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<td>($800 2006)</td>
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<tr>
<td>Resident of an adult family home</td>
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<td>$1648</td>
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<td>Resident of an adult community alternative home</td>
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<td>Resident of an adult residential facility</td>
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<tr>
<td>Person receiving adult community mental health</td>
<td>$618</td>
<td>$1236</td>
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<tr>
<td>housing services</td>
<td>($600 2006)</td>
<td>($1200 2006)</td>
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</table>

Action Required: Table TOSS will be updated before CRISE cutoff on October 22, 2007 for November 2007 budgets. A CLVB dated 10/5/07 has been posted to assist counties in identifying affected RSS cases. The eligibility worker will need to run ED/BC for each identified RSS case. Manual budgets must be recalculated retroactively to July 1, 2007. Supplemental payments must be issued for each case that did not include the July 2007 increase.

MEM Instructions:
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MEPL 6 (Medicaid: Healthy families eligibility contraction from 100% federal poverty level (FPL) to 90% FPL)

Medicaid Eligibility Procedure Letter No. 6

November 28, 2005

Effective Date: January 1, 2006

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Medicaid: Healthy families eligibility contraction from 100% federal poverty level (FPL) to 90% FPL

Reason for Change: Amendments to Ohio Revised Code 5111.019 in the budget bill Am. Sub. H.B. 66 requires the Director of Ohio Department of Job and Family Services (ODJFS) to submit to Center for Medicare and Medicaid Services a state plan amendment which would require the reduction of family income from 100% FPL to 90% of the FPL for healthy families Medicaid income eligibility.

Prior Policy: Current income eligibility for healthy families Medicaid cannot exceed 100% of the FPL.

New Policy: Effective January 1, 2006, income eligibility for healthy families Medicaid cannot exceed 90% of the FPL. The 90% FPL standard shall be used on all applications received and eligibility redeterminations completed on or after January 1, 2006. For all applications received and for eligibility redeterminations completed prior to January 1, 2006, the 100% FPL standard must be applied.

Action Required: Two new reason codes must be used when denying or terminating any healthy families Medicaid application due to income exceeding 90% of the FPL. These codes will become effective on January 1, 2006, when the new poverty standard can be applied to new applications and redeterminations.

<table>
<thead>
<tr>
<th>New Reason Codes</th>
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<tbody>
<tr>
<td>Reason Code</td>
</tr>
<tr>
<td>663</td>
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<td>692</td>
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The 90% poverty level will become effective January 1, 2006. The table below provides information on the new poverty level. Income standards will change February 2006 when the United States Department of Health and Human Services updates the FPL guidelines. The CDJFS will be notified of the FPL updates via a subsequent MEPL issuance.

<table>
<thead>
<tr>
<th>New Poverty Level</th>
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<tr>
<td>Family Size Monthly</td>
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A [view flash bulletin](#) will be issued with the information contained in this MEPL.

MEM Instructions:

This MEPL is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
**Action Change Transmittals**

**Action Change Transmittals** (ACTs) are authored by the Medicaid Eligibility Policy Section to quickly relay policy changes or introduce a special project. ACTs are used when it is required to communicate a change in policy prior to incorporating the change into the Medicaid Eligibility Manual. They are also used to notify of a policy change that does not originate in the department - e.g. federal poverty index. ACTs are considered policy and shall be implemented.
Effective Date: April 1, 2004
TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: Medicaid: Changes within the Systematic Alien Verification for Entitlements (SAVE) Program

Reason for Change:
The Systematic Alien Verification for Entitlements (SAVE) Program is providing an improved and more efficient system to perform immigration status verifications.

Prior Policy:
In 1986 Congress passed the Immigration Reform and Control Act of 1986 (IRCA), which required the Immigration and Naturalization Service (INS) to establish a system for verifying the immigration status of non-citizen applicants for certain types of Federally funded benefits. In 1987 the INS established the Systematic Alien Verification for Entitlements (SAVE) Program to satisfy this requirement.

Note: On March 1, 2003 the responsibility for providing immigration-related services and benefits were transferred from the INS to the U.S. Citizenship and Immigration Services (USCIS), a bureau of the Department of Homeland Security (DHS).

A component of the SAVE Program is the Alien Status Verification Index (ASVI), containing a nationally accessible database of selected immigration status information on more than 60 million non-citizens. The ASVI system has met the needs of the Department for several years, however, SAVE is now providing a more efficient system to perform immigration status verifications.

New Policy:
The new system is called, "Automated Status Verification System" (ASVS).

ASVS provides the following benefits:

- Faster and better verification process, including an electronic secondary verification;
- Reduced response time for secondary verification;
- Fully automated means for verifying immigration status information;
- Paperless environment eliminating the submission of the Form G-845;
- Paperless audit trail;
- Increased data security and integrity; and
- Quicker Medicaid/Food Stamp/Cash Assistance eligibility determinations.

Action Required:
No action is required by county agencies, as all agencies received access to the ASVS system effective March 1, 2004. Please refer to CAMTL No. 14 or FSTL No. 256 for details regarding ASVS system usage.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.

This information is also available on the Internet and may be accessed at:

The ODJFS Electronic Manuals (previously known as dynaweb) has moved.

Please update your Bookmarks/Favorites in your Internet browser:
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/

The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.
ACT 228 (QI-1 Reinstatement)
Action Change Transmittal Letter No. 228

October 16, 2003

Effective Date: October 1, 2003
OAC Rules: 5101:1-39-01.1

TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: Reinstatement of the Qualified Individuals-1 (QI-1) program

Reason for Change: On October 1, 2003, President George W. Bush signed into law H.R. 3146. This bill extends the QI-1 program through March 31, 2004.

Prior Policy: The QI-1 program expired on September 30, 2003. Individuals who were in receipt of QI-1 benefits (i.e., payment of the Medicare Part B premium) were removed from the Buy-In effective October 1, 2003 and the QI-1 case was terminated effective September 30, 2003. Retroactive coverage, but no ongoing QI-1 coverage was available to individuals for months prior to October 2003.

New Policy: Effective October 1, 2003, the QI-1 program has been extended through March 31, 2004. Individuals whose QI-1 benefits were terminated effective September 30, 2003 will be reinstated and re-enrolled in the Buy-In effective October 1, 2003. Individuals who were approved for retroactive coverage only because the QI-1 program was expiring effective September 30, 2003 may now be approved for ongoing coverage.

Action Required:
The following actions will be taken by ODJFS as part of the process to reinstate the QI-1 cases:

A mass change will be run to issue alert 886 "MAUS QI-1 Reinstatement" for the following cases:

1) QI-1 cases that were terminated effective September 30, 2003 due to the expiration of the QI-1 program.

2) QI-1 cases that were approved for retroactive coverage only and denied for recurring benefits beginning October 2003.

The following actions are to be taken by the CDJFS to reinstate the QI-1 cases:

1) For assistance groups that currently have no open cases in CRIS-E, eligibility must be rerun under AEORE using an October 1, 2003 signature date on AEFPY and reason code 141.

2) For assistance groups that have other categories of assistance currently open in CRIS-E, eligibility must be rerun under AEONG using an October 1, 2003 signature date on AEFPY and reason code 141.

3) For applications that are still pending, a CRIS-E View Flash Bulletin was issued on October 2, 2003 requesting that all pending QI-1 applications be held until further notice. QI-1 eligibility and authorization should now be processed as usual. Alert 886 will not be issued for these assistance groups. Do not use reason code 141 to authorize QI-1 assistance.

All affected cases must be reauthorized in CRIS-E as soon as possible in order for the Buy-In Unit to add these individuals without undue delay. It is anticipated that the affected individuals should have the reinstatement of the buy-in completed and the premium no longer deducted from their Social Security checks for December 2003. The individual will also receive a lump sum reimbursement from Social Security for October and November.

The expanded text for reason code 141 on the CRIS-E approval notice for the QI-1s reads as follows:
"We will start paying your monthly Medicare Part B premium again under the "QI-1" program. We will pay for Oct. 2003 and months after. In Dec. 2003, S.S.A. should increase your monthly S.S. check and send you a refund for the premiums you paid for Oct. and Nov."

This reason code is to be used only for those applications that were terminated or denied for ongoing QI-1 benefits effective September 30, 2003. It is not to be used when determining initial eligibility.

Reminder: You must also review any other categories of assistance (i.e., Medicaid or Food Stamps) that may be affected by the reinstatement of the QI-1 program. The SSA refund of the

Medicare premium is considered a non-recurring lump sum reimbursement and does not affect Medicaid in the month the refund is received. Reference OAC rule 5101:4-4-07(B) for the treatment of the lump sum for Food Stamp purposes.

If the CDJFS becomes aware of any QI-1 assistance groups that were denied or terminated due to the expiration of the QI-1 program and an alert was not issued for the assistance group, the CDJFS must redetermine the assistance group's eligibility for QI-1.

A CRIS-E View Flash Bulletin (CLVB) has also been issued with the information contained in this ACT.

This ACT is also available on the Internet and may be accessed at:
http://dynaweb.oddfs.state.oh.us:6336/dynaweb/ohpelegibility/MEM.

You can also access new issuances of policy at Legal/Policy Central calendar which is available on the Internet at: http://www.odjfs.state.oh.us/lpc/calendar/index.asp. The calendar provides a daily list of policy letters with links to the electronic manuals and to printable (PDF) versions.

Please have your designated staff contact the CRIS-E Help Desk for questions or concerns.
ACT 227 (QI-1 Program Shut-Down)

Action Change Transmittal Letter No. 227

September 5, 2003

Effective Date: October 1, 2003


TO: All Medicaid Eligibility Manual Holders

FROM: Thomas J. Hayes, Director

SUBJECT: QUALIFIED INDIVIDUALS-1 (QI-1) PROGRAM SHUT-DOWN

Reason for Change: The time period for the Qualified Individual-1 program, as established in Section 4732 of the Balanced Budget Act (BBA) of 1997, has expired. Section 4732 of the BBA of 1997 established Federal funding for two Medicaid categories, Qualified Individuals-1 (QI-1) and Qualified Individuals-2 (QI-2) from January 1998 to December 2002. These two programs were 100% Federally funded, and must be reauthorized through Federal legislation in order to continue. The QI-2 program was not reauthorized and expired on December 31, 2002. A Continuing Resolution temporarily extended only the QI-1 program. The Continuing Resolution extension expired on September 30, 2003.

Prior Policy: The QI-1 program was scheduled to sunset December 31, 2002 and was extended through federal Continuing Resolutions until September 30, 2003.

QI-1: The income limit is between 120 percent and 135 percent of poverty. Medicaid pays the monthly Medicare Part B premium for individuals in this category.

New Policy:

QI-1: The Qualified Individuals-1 program will sunset on September 30, 2003 and there has been no Continuing Resolution to further extend coverage for this group. This means that there is no longer any Federal funding for the Medicare Part B.

Action Required:

Notices will be issued in September notifying all MAUS (QI-1) assistance groups that eligibility will be terminated effective September 30, 2003. An advance notice was issued the week of August 18 advising all QI-1 assistance groups of the pending action. The Medicaid Buy-in Unit has notified the Social Security Administration that Ohio will no longer be paying the Medicare Part B premium for these individuals. No additional action is required by the CDJFS, unless the assistance group indicates changes or the CDJFS is otherwise aware of changes in information since the last eligibility determination. In that case, explore eligibility for other categories of Medicaid. Individuals are not able to appeal the loss of their QI-1 coverage due to this being a change in Federal law.

A CRIS-E View Flash Bulletin has been issued.
ACT 223 (QI1)

Action Change Transmittal Letter No. 223

March 12, 2003

Effective Date: March 3, 2003


TO: All Medicaid Eligibility Manual Holders

FROM: Thomas J. Hayes, Director

SUBJECT: Qualified Individuals-1 (QI-1) Update

Reason for Change:
The time period for the Qualified Individuals program, as established in Section 4732 of the Balanced Budget Act (BBA) of 1997, has expired. Section 4732 of the BBA of 1997 established Federal funding for two Medicaid categories, Qualified Individuals-1 (QI-1) and Qualified Individuals-2 (QI-2) from January 1998 to December 2002. These two programs were 100% Federally funded, and must be reauthorized through Federal legislation in order to continue.

Prior Policy:
QI-1: The income limit is between 120 percent and 135 percent of poverty. Medicaid pays the monthly Medicare Part B premium for individuals in this category.

New Policy:
US Congress has passed the federal budget for FY 2003. The budget contains funding for the QI-1 program through September 30, 2003.

Action Required:
Do not take any action to notify or terminate QI-1s at this time.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.
ACT 222 (HIPPA Notice)
Action Change Transmittal Letter No. 222

March 12, 2003

Effective Date: February 21, 2003

TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: ODJFS HIPAA Privacy Notice

Reason for Change: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all covered entities such as the Ohio Department of Job and Family Services to send a "HIPAA Privacy Notice" to all of its "members" (i.e., recipients of medical programs) by April 14, 2003, the date the federal HIPAA privacy regulations take effect. The notice details a member's privacy rights under HIPAA and it details how we might use and disclose a member's protected health information (PHI).

Prior Policy: N/A

New Policy: The ODJFS HIPAA Privacy Notice can be viewed at www.state.oh.us/odjfs/hipaa/privacy.pdf. Nearly one million copies of this notice will be sent via CRIS-E to approximately 851,000 Medicaid, Covered Families and Children (CFC) Medicaid, DA Medical, and Refugee Medical assistance groups and their authorized representatives. Due to the number of notices being sent, the mailing will be staggered over ten (10) dates with approximately 100,000 copies of the notice mailed on each date. The dates of the mailings will be: 2/21, 2/24, 3/3, 3/6, 3/10, 3/13, 3/17, 3/20, 3/31 and 4/3/03.

Action Required: The notices will be mailed to the most recent address known to CRIS-E (on AEICI, AEFAR, or AEFAM) at the time of the mailing. The return address will be that of the CDJFS in the county in which the recipient resides. If a CDJFS receives an undeliverable notice via returned mail, every attempt should be made to verify the correct address in the case record and to re-mail the ODJFS HIPAA Privacy Notice to the correct address. If the notice cannot be re-mailed from the CDJFS to the CDJFS' last known/best address for the individual, the notice should be filed in the individual's case file along with the postal verification that the notice was undeliverable.

HIPAA also requires that we send a copy of our privacy notice to all newly found eligible recipients of Medicaid, CFC Medicaid, DA Medical, and Refugee Medical on and after 4/14/03. The return address will be that of the CDJFS and again, every attempt should be made to mail the notice to the correct address, should a notice be returned to your agency as undeliverable. If it cannot be re-mailed to the last known/best address for the individual, the notice should be filed in the individual's case file along with the postal verification that the notice was undeliverable.

Additionally HIPAA requires us, at a minimum of once every three years, to notify our members/recipients of Medicaid, CFC Medicaid, DA Medical, and Refugee Medical about how they may obtain a copy of the HIPAA Privacy Notice. To meet this federal requirement, a brief paragraph will be added to the hearing rights notices for all of the aforementioned programs. The paragraph informs recipients that federal law requires us to keep their health information private and that they may obtain a copy of the HIPAA Privacy Notice by visiting the website above or by calling the Ohio Medicaid Consumer Hotline at (800) 324-8680.

The privacy notices which are part of the initial mass mailing will appear on CNHS as HI01I9. They are not available to request a duplicate notice or to request a copy. The privacy notices which will be mailed to new recipients on and after 4/14/03 will appear on CNHS as HI01I2. They are available for copy and duplicate requests.

A CRIS-E View Flash Bulletin (CLVB) was issued February 19, 2003 with the information and procedures contained herein.
ACT 221 (QI-1 and QI-2 shut down)

Action Change Transmittal Letter No. 221

January 23, 2003

Effective Date: December 31, 2002


TO: All Medicaid Eligibility Manual Holders

FROM: Thomas J. Hayes, Director

SUBJECT: QUALIFIED INDIVIDUALS-1 (QI-1) AND QUALIFIED INDIVIDUALS-2 (QI-2) PROGRAMS SHUT-DOWN

Reason for Change: The time period for the Qualified Individuals program, as established in Section 4732 of the Balanced Budget Act (BBA) of 1997, has expired. Section 4732 of the BBA of 1997 established Federal funding for two Medicaid categories, Qualified Individuals-1 (QI-1) and Qualified Individuals-2 (QI-2) from January 1998 to December 2002. These two programs were 100% Federally funded, and must be reauthorized through Federal legislation in order to continue. A Continuing Resolution has temporarily extended only the QI-1 program.

Prior Policy: Both of the Qualified Individuals programs (QI-1 and QI-2) were scheduled to sunset December 31, 2002.

QI-1: The income limit is between 120 percent and 135 percent of poverty. Medicaid pays the monthly Medicare Part B premium for individuals in this category.

QI-2: The income limit is between 135 percent and 175 percent of poverty. Medicaid pays the home health care portion of the Medicare Part B premium for individuals in this category.

New Policy:

A. QI-1: The Qualified Individuals-1 program did not sunset December 31, 2002. A Continuing Resolution (Pub. L. No. 107-229, as amended by Pub. L. Nos. 107-240 and 107-244, and most recently amended by Pub. L. No. 107-294) has been enacted that extends, at current funding levels, the QI-1 benefit through March 12, 2003. This means that there is Federal funding for the Medicare Part B premiums through the entire month of March 2003 for individuals who have enrolled as QI-1s prior to March 13, 2003.

B. QI-2: The Qualified Individuals-2 program did sunset December 31, 2002, and there was no Continuing Resolution to further extend coverage for this group.

Action Required:

A. QI-1: Do not take any action to notify or terminate QI-1s at this time.

B. QI-2: No action required, unless the assistance group indicates changes or the county is otherwise aware of changes in information since the last eligibility determination. In that case, explore eligibility for other categories of Medicaid. Individuals are not able to appeal the loss of their QI-2 coverage due to this being a change in Federal law.
Medicaid Information Letters (MILs) are authored by the Medicaid Eligibility Policy Section and County Oversight and Support Section to provide information or clarification of existing rules and policies. MILs are not policy and do not change or obsolete a rule.
MIL 04-016 (Disability Medical Assistance Administrative Order)

Medicaid Information Letter: 04-016

November 22, 2004

To: Directors, County Departments of Job and Family Services

From: Thomas J. Hayes, Director

Subject: Disability Medical Assistance Administrative Order

The Director of the Ohio Department of Job and Family Services (ODJFS), pursuant to rule 5101:1-42-01 of the Ohio Administrative Code, issues this Administrative Order to eliminate the one month grace period after the termination of Disability Medical Assistance (DMA) effective December 1, 2004.

The Disability Medical Assistance program remains under an administrative freeze as defined in MIL 04-015. Individuals whose DMA cases have terminated as of November 30, 2004 or later will no longer be granted a one month grace period after the termination of DMA. If an individual applies after the effective date of termination, they will be subject to the administrative freeze.

The CDJFS must complete a pre-termination review (PTR), in accordance with 5101:1-42-01 (F)(10) of the Ohio Administrative Code, for continuing eligibility for DMA and Medicaid. Proper notice of hearing rights must be issued at time of termination of DMA eligibility and reinstatement of assistance granted to anyone who requests a hearing within the timely notice period.

Medicaid Information Letter: 03-009A will become obsolete effective December 1, 2004, when this MIL will take effect.

This information is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/oheligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MIL 04-015 (DMA Administrative Order)

Medicaid Information Letter: 04-015

September 3, 2004

To: Directors, County Departments of Job and Family Services

From: Thomas J. Hayes, Director

Subject: Disability Medical Assistance Administrative Order

The Director of the Ohio Department of Job and Family Services (ODJFS), pursuant to rule 5101:1-42-01 of the Ohio Administrative Code, issues this Administrative Order to suspend the approval of all applications for Disability Medical Assistance.

Under this administrative order, all county departments of job and family services (CDJFS) must upon receipt of this order:

1. Deny all new applications for Disability Medical Assistance (DMA) that are received on or after September 15, 2004, until such time as this order is revised or rescinded.

2. Determine eligibility for DMA applications that are still pending an eligibility determination as of September 14, 2004. The CDJFS must use the DMA rule 5101:1-42-01 that is in effect prior to September 15, 2004.

3. Determine continued DMA eligibility for individuals at their regularly scheduled redetermination. If the individual does not meet the eligibility requirement of medication dependency, continuing eligibility must be terminated in accordance with appropriate notice and state hearing procedures.

Instructions for Implementation of this Administrative Order

In accordance with ORC 5115.12, the following instructions are to be followed for the purpose of implementing this Administrative Order:

1. The agency must deny all new applications for DMA received on or after September 15, 2004, using reason code 693.

2. For all pending applications and JFS 02453-Inpatient Hospital Referral Forms submitted prior to September 15, 2004, the agency must continue to determine DMA eligibility using rule 5101:1-42-01.

3. The agency must issue a prior notice of termination, using reason code 499, when a recipient is no longer eligible for DMA as a result of eligibility redetermination.

4. The agency must allow a one month grace period after the termination of DMA in which the individual may reapply for DMA without being subject to the administrative freeze per MIL 03-009A.

This information is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
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Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
To: Directors, County Departments of Job and Family Services  
From: Thomas J. Hayes, Director  
Subject: Medicare-Approved Drug Discount Card

August 12, 2004

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the Medicare-Approved Drug Discount Card to provide Medicare beneficiaries prescription drug discounts. In both 2004 and 2005, certain low-income Medicare beneficiaries who have a discount card may also qualify for additional assistance in the form of a $600 credit (called, "Transitional Assistance" by CMS; not to be confused with Transitional Medicaid) that the beneficiary can use to pay for prescription drugs. Medicare beneficiaries who qualify for the $600 credit may also receive additional savings from prescription drug manufacturers who are partnering with the Medicare-Approved drug card sponsors. This partnership will provide significant discounts and in some cases, free drugs to beneficiaries who have used up their $600 credit.

Section 1860D-31(g)(6) of the Social Security Act states that benefits from the Medicare-Approved Drug Discount Card "shall not be treated as benefits or otherwise taken into account in determining an individual's eligibility for, or the amount of benefits under, any other Federal program." This means that a person should not be disadvantaged under other Federal programs, including Medicaid, because he or she is getting a discount under a Medicare-Approved Drug Discount Card or the $600 credit to help pay for prescription drugs. This policy is effective June 1, 2004.

Administrative Agency Responsibilities:

1. Individuals whose Spenddown or patient liability budgets were denied, delayed or were adversely impacted since June 1, 2004, because this new guidance was not applied shall have their cases reviewed. Upon identifying such cases (due to incurred medical expenses associated with the Medicare-approved drug card or the $600 credit), the administrative agency may have to backdate Medicaid eligibility or apply the provisions for refunding Spenddown pay-in payments in accordance with rule 5101:1-39-10 of the Administrative Code.

2. An individual on Spenddown may be denied the Medicare-approved drug card or the $600 credit because Medicare shows the individual was eligible for or in receipt of Medicaid during the time the individual applied for the Medicare-approved drug card or the $600 credit. The individual will then need to provide documentation that shows his or her Medicaid benefits were stopped during the time he or she applied for the Medicare-approved drug card or the $600 credit. The administrative agency, upon request, shall provide documentation to an individual that verifies whether or not the individual was eligible for Medicaid benefits at the time he or she applied for the Medicare-approved drug card or the $600 credit.

Spenddown and application for the Medicare-Approved Drug Discount Card and $600 credit:

Individuals on Spenddown who are interested in applying for the Medicare-approved drug card or the $600 credit should apply for the Medicare-approved drug card or $600 credit during a time when the individual has not met Spenddown for the month (either by the incurred or pay-in method).

Spenddown eligibility with the Medicare-Approved Drug Discount Card and $600 Credit:

1. Any portion of the $600 credit for both 2004 and 2005 that is used to pay for prescription drugs should be treated as a medical expense incurred by the individual and applied as such.

2. The incurred medical expense is the amount the individual would have had to pay in the absence of the Medicare-approved drug card. For purposes of establishing the amount of the incurred medical expense, the "pre-discount price" of a prescription is what the individual would have had to pay if he or
she were not enrolled in the Medicare-approved drug card. This information may be available via prescription receipts.

3. If information about the pre-discount prescription price is not readily available, the administrative agency can use receipts for prescriptions that the individual purchased before enrolling for a Medicare-approved drug card to determine the amount incurred. The administrative agency may also call the pharmacy where the prescription was filled to find out the pre-discount price of a prescription.

4. If the administrative agency cannot determine the actual pre-discount prescription price, the administrative agency shall use a value of $48.17 (per prescription) as a substitute for the actual pre-discount price. This amount represents the national average cost per prescription for the cash-paying customer in 2003. This means that in absence of an actual pre-discount prescription price, a prescription purchased by an individual under a Medicare-approved drug card will be assumed to have a pre-discount price of $48.17 (per prescription) and that amount will be treated as the incurred medical expense for that prescription for Spenddown purposes. However, if an individual can provide satisfactory evidence that he or she would have paid more than the $48.17 value, the administrative agency shall use the amount the individual can document as the incurred medical expense.

5. Discount card enrollment fee: Medicare beneficiaries may be charged an enrollment fee of up to $30 per year for the Medicare-approved drug card. Under certain circumstances the enrollment fee may be paid by the Federal or state government rather than by the beneficiary. Any annual fee paid by an individual on Spenddown for a Medicare-approved drug card shall be treated as an incurred medical expense. However, any annual fee paid by the Federal or state government shall not be treated as an incurred medical expense.

Medicaid patient liability with the Medicare-Approved Drug Discount Card and $600 Credit:

1. For Medicaid third party liability purposes, no portion of the $600 credit that is used to pay for prescription drugs should be treated as an available resource under Medicaid. This means that an individual with a Medicare-approved drug card and the $600 credit who is also eligible for Medicaid does not have to spend the $600 credit before Medicaid will pay for his or her prescription drugs.

2. If an individual has a Medicare-approved drug card or both the discount card and the $600 credit, and is subject to a patient-liability budget while in a medical institution, the above guidance on treatment of a discount and the $600 credit for Spenddown purposes is applicable. Neither the $600 credit nor any discount savings arising from the Medicare-approved drug card shall be counted as income in the patient liability budget process.

Q and A:

1. **Who qualifies for the Medicare-Approved Drug Discount Card?**
   **Answer:** Medicare beneficiaries enrolled in Part A and/or Part B who do not have any Medicaid outpatient prescription coverage at the time of application. There are no income qualifications.

2. **Who qualifies for the $600 credit?**
   **Answer:** Medicare beneficiaries enrolled in Part A and/or Part B who have no other health insurance with prescription drug coverage (except Medicare Advantage or Medigap) and who have income at or below 135% of the federal poverty level (FPL).

3. **Can Medicare beneficiaries who apply for Spenddown qualify for a Medicare-approved drug card?**
   **Answer:** Yes. Individuals who are not currently on Medicaid, who are on Spenddown but who have not yet met their Spenddown for the month, and who are not receiving outpatient drug coverage from any other health plan may apply for the card and the $600 credit. Further, individuals will remain eligible for the card and the $600 credit even if the individual later meets his or her Spenddown and gains access to Medicaid coverage.

4. **Will the $600 credit or discounts available to card holders prevent or delay an individual’s eligibility for Spenddown?**
No. Neither the $600 credit nor the discount prices shall prevent or delay an individual’s eligibility for Medicaid. The discount and the $600 credit will be treated as incurred medical expenses for Spenddown.

**5. Will the price of prescription drugs purchased with the Medicare-approved drug card be deducted from the income in a Spenddown budget?**

**Answer:** Yes. The price of prescription drugs purchased with the Medicare-approved drug card will be treated as incurred medical expenses toward meeting Spenddown.

**6. Can an individual who meets his or her Spenddown through the Pay-In option get a Medicare-approved drug card and the $600 credit?**

**Answer:** Only if the individual’s Medicaid coverage lapses (i.e., the individual has not met Spenddown for the month). Because an individual is eligible for Medicaid (and prescription medication coverage) the 1st of the month an individual pays in the Spenddown amount, he or she would not qualify for a Medicare-approved drug card or the $600 credit. Therefore, the individual must apply for the Medicare-approved drug card or the $600 credit during a time when the individual has not met Spenddown or paid in the Spenddown for the month he is applying for the Medicare-approved drug card. However, any time an individual has a lapse in Medicaid coverage, he or she may apply for the Medicare-approved drug card and $600 credit.

**7. If an individual gets the $600 credit and later becomes eligible for Medicaid, does the individual lose the credit?**

**Answer:** No. The individual will not lose the credit. In this situation, Medicaid becomes the primary payer for drugs covered by Medicaid. The individual can save whatever remains of the $600 credit to use in the future should he or she lose Medicaid benefits (or to use for drugs that are not covered by Medicaid), until the time that outpatient drug coverage becomes available from the new Medicare Prescription Drug Plans.

**8. What if an individual on Spenddown applies for the Medicare-approved drug card or the $600 credit and is denied because the individual is erroneously considered receiving Medicaid during the time of application for the Medicare-approved drug card or the $600 credit?**

**Answer:** The individual should follow the instructions in the denial letter for reconsideration. The individual will then need to provide documentation that shows his or her Medicaid benefits were stopped during the time he or she applied for the Medicare-approved drug card or the $600 credit. The administrative agency, upon request, shall provide documentation to an individual that shows the individual’s Medicaid benefits were stopped at the time he or she applied for the Medicare-approved drug card or the $600 credit. (Refer also to #2 under "Administrative Agency Responsibilities" in this MIL).

This information in this MIL is also available via a CRIS-E view flash bulletin (CLVB) and on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/oheligibility/MEM

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar
The purpose of this Medicaid information Letter is to bring to your attention the Ohio Administrative Code rule 5101:9-6-50, ODJFS Grants, as it relates to Medicaid eligibility rules. Amended Substitute House Bill 95 highlights that the Ohio Department of Job and Family Services (ODJFS) receives federal funds from numerous federal agencies in the form of grant agreements and will enter into fiscal agreements with local areas to provide assistance. Local agencies have a responsibility to comply with the terms and conditions of the grant, including program and fiscal requirements in the use of the financial assistance.

This rule became effective October 1, 2003 and provides detail on the responsibility and accountability of grantees that receive federal grants from federal agencies. The CDJFS is defined as a county family services agency, and must administer programs consistent with the requirements of the federal grant whether or not the agency is included in a fiscal agreement. As a condition of receiving financial assistance, each family services agency must comply with the conditions of the federal grant.

Laws and regulations that govern the determination of eligibility for Title XIX, XXI and State Child Health Insurance Program (SCHIP) include, but are not limited to, the Code of Federal Regulation, Title 42--Public Health, Part 435--Eligibility, The Ohio Revised Code and The Ohio Administrative Code. The CDJFS must be sure that it complies with all of the program requirements associated with administration of these programs.

Also, as stated in the Administrative Procedure Manual Transmittal Letter No. 262, each county family services agency shall monitor each private and government entity that receives financial assistance from the county agency to ensure that the administration of any delegated family services duties are in compliance with federal, state and local requirements. In case a delegated duty is determined to be out of compliance with any administrative program requirement(s), the county family services agency shall require the entity to promptly comply with a corrective action plan approved by the county agency and shall take prompt action to recover any financial assistance that is not expended in accordance with state, federal, and local requirements.

The Medicaid eligibility rules are located online in the Medicaid Eligibility Manual at: http://emanuals.odjfs.state.oh.us/emanuals. In the near future you will also be able to access the Medicaid eligibility State Plan online.

This information is also available on the Internet and may be accessed at:

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar

The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 severed the categorical link between the Medicaid and former ADC programs. As a result, some individuals who are no longer eligible for cash assistance, whether through receipt of OWF, Title IV-E foster care maintenance or Title IV-E Adoption Assistance, may continue to remain eligible for Medicaid coverage under other categories of Medicaid. To assure uninterrupted Medicaid coverage whenever possible, the federal government and OAC rule 5101:1-38-01.1 require that a pre-termination review (PTR) of continuing Medicaid coverage be completed before stopping an individual's Medicaid benefits.

Children eligible for Title IV-E foster care maintenance payments or adoption assistance are automatically eligible for Medicaid. For these children, a PTR must be completed by the CDJFS prior to the termination of the Medicaid coverage whenever a child's foster care maintenance payments or adoption assistance eligibility is ending. Although the Title IV-E Medicaid case is maintained in FACSIS rather than CRIS-E, it is still the state’s responsibility to ensure that Medicaid coverage is not interrupted before the CDJFS has had an opportunity to complete a PTR for the child. This letter establishes the procedure for coordination between the PCSA and CDJFS to ensure the timely completion of the PTR for Title IV-E eligible children.

In order to assure a smooth implementation of this process, each CDJFS must identify a Title IV-E Medicaid coordinator to function as the single point of contact between the PCSA and CDJFS. Please e-mail identifying information about your coordinator (county, name, telephone number and e-mail address) to wellsl@odjfs.state.oh.us by September 15, 2003. This information will be made available to all CDJFSs and PCSAs after it is compiled.

This information is also available on the Internet and may be accessed: at either:

http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM or
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/family.

Attachment: JFS 01958 “Referral for Continuing Medicaid Eligibility Review”

**PCSA Responsibilities for Pre-termination review of Title IV-E cases**

Prior to terminating a child's Title IV-E foster care maintenance or adoption assistance Medicaid, the PCSA must complete a JFS 01958 "Referral for Medicaid Continued Eligibility Review" form and fax or hand deliver it to the appropriate CDJFS’ Title IV-E Medicaid coordinator. This referral should be completed as soon as the PCSA becomes aware that the child's foster care maintenance (FCM) eligibility or reimbursibility is ending or that the adoption assistance (AA) case is being terminated. The **PCSA must provide notice to the CDJFS at least 8 working days prior to the termination of the Title IV-E Medicaid.**

1) For changes in **FCM** eligibility or reimbursibility the JFS 01958 referral should be sent to the appropriate CDJFS as follows:

   (a) When the child is leaving the custody of the PCSA the referral is sent to the CDJFS in the Ohio county where the child will be residing after his removal from placement.
(b) When the child is remaining in the custody of the PCSA or other IV-E agency the referral is sent to the CDJFS in the same county as the PCSA.

(c) When the child will be residing out of state after removal from placement no referral is necessary.

2) For changes in AA eligibility the JFS 01958 referral should be sent to the appropriate CDJFS as follows:

(a) To the CDJFS in the Ohio county where the child will be residing after the termination of the AA agreement.

(b) No referral is necessary when the child will be residing out of state after termination of the AA agreement.

For questions about this procedure, the PCSA should contact the OCF Helpdesk at helpdeskocf@odjfs.state.oh.us.

**Instructions for FCSAM users:**

Insert the following into the Family, Children, and Adult Services Manual (FCASM):

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>REMOVE AND FILE AS OBSOLETE</th>
<th>INSERT/REPLACEMENT</th>
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</thead>
<tbody>
<tr>
<td>Transmittals/Procedure Letters</td>
<td></td>
<td>FCASPL No. 72</td>
</tr>
<tr>
<td>Forms</td>
<td></td>
<td>JFS 01958</td>
</tr>
</tbody>
</table>

**CDJFS Responsibilities for Pre-termination review of Title IV-E cases**

1) Immediately upon receipt of the JFS 01958 referral, the CDJFS must authorize either Healthy Start or Medicaid for children under 21 (MA-T) based on the information contained in the referral.

2) The CDJFS must then begin a continuing eligibility review in accordance with the provisions in rule 5101:1-38-01.1 and notify the assistance group of the CDJFS’s decision.

For questions about this procedure the CDJFS should contact the CFCTA staff at CFCTA@odjfs.state.oh.us.
In December 1995, ODJFS requested that each County Department of Job and Family Services retain the complete case files which dealt with Medicaid applicants who were in a nursing home and had a community spouse. This request was prompted by the federal case of Chambers v. ODHS. Although the Chambers v. ODHS, has been successfully resolved a related case in the Ohio Court of Claims, George v. ODHS, requires that these case records still be maintained. Some questions recently arose regarding record retention in relation to these case records.

Question #1: Does the CDJFS have to retain all case records related to Chambers v. ODHS?
Response #1: Yes, all case records must be retained as the George v. ODHS case is still open and affects the same class of people that were part of the Chambers v. ODHS litigation.

Question #2: Does the hard copy case record need to be retained, or, in lieu of keeping the hard copy case record, may alternative means of keeping the case records be utilized?
Response #2: Yes, readable, retrievable images may substitute for the original case records. However, in the event that Chambers' case records are required to be made available, the CDJFS will be required to produce the records in hard copy.

This information is also available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM
MIL 03-008 (HIPAA Compliant Forms)

Medicaid Information Letter: 03-008

May 20, 2003

To: Directors, County Departments of Job and Family Services

From: Rick Keefer, Section Chief
Medicaid Eligibility Policy

Subject: Health Information Portability and Accountability Act (HIPAA) Compliant Forms

The purpose of this letter is to inform County Departments of Job and Family Services that the Medicaid Eligibility Manual (MEM) now houses HIPAA compliant templates to use when releasing or requesting protected health information (PHI). The forms are located in the Appendix of the MEM. A CDJFS template for the JFS 03397, "ODJFS Authorization for the Release or Use of Protected Health Information" is now available on the ODJFS website under the "HIPAA Information and Forms" link. Direct web links are located at the end of this letter.

**Issues related to the CDJFS releasing protected health information to a third party:**

**The JFS 03397**

ODJFS developed a HIPAA compliant authorization form, the JFS 03397. This form serves as authorization for ODJFS to release protected health information (PHI) to a third party who is requesting the PHI. This form is intended to be used only by ODJFS. However, counties may develop their own county-specific HIPAA compliant form using the JFS 03397 as a guide.

**The CDJFS Template for the JFS 03397**

Counties may also use the template which was adapted from the JFS 03397, entitled "Authorization for the Release or Use of Protected Health Information (PHI)". This form is HIPAA compliant, and the county can place their letterhead in the upper left corner of this authorization form. The CDJFS template serves as authorization for the CDJFS to release protected health information (PHI) to a third party who requests it.

**The "Suggested Format for Informed Release"**

This form recently was revised to be in compliance with HIPAA regulations. When the CDJFS uses this form they must also include a signed HIPAA compliant authorization form (as described in the previous paragraph.)

Policy regarding the release of or request for protected health information is outlined in OAC rule 5101:1-37-01.1, Medicaid: Disclosure of Recipient Information and Confidentiality.

Both the CDJFS template for the JFS 03397 and the Suggested Format for Informed Release forms are used when the CDJFS is releasing information to a third party.

**Issues related to the CDJFS requesting protected health information from a third party:**

Questions have come up regarding obtaining PHI from a third party, such as a medical provider. Medical providers, hospitals, pharmacies, etc., are considered covered entities. The burden to safeguard the protected health information rests with the covered entity. Therefore, when the CDJFS submits a signed authorization (whether HIPAA compliant or not) to a third party (covered entity), the third party is not obligated to accept it. The third party (covered entity) may have its own HIPAA compliant authorization which the Medicaid recipient will need to sign.

It has been suggested by ODJFS HIPAA compliance officials that the CDJFS contact providers that they deal with on a regular basis and ask for a copy of their HIPAA compliant authorizations. The CDJFS may keep the forms on hand and submit these signed authorizations to providers when requesting the release of medical information.

**The JFS 03607:** This form is obsolete. Following the guidelines in this letter should help the CDJFS receive necessary medical information from third parties.
This information is available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM
http://www.state.oh.us/odjfs/ohp/hipaa.stm
To: Directors, County Departments of Job and Family Services
From: Rick Keefer, Section Chief
Medicaid Eligibility Policy
Subject: JFS 01137, "Child Care/Healthy Start and Healthy Families Supplement"

The purpose of this letter is to inform County Departments of Job and Family Services that the Bureau of Child Care and Development has created a supplement to the "Child Care Application," JFS 01138. This supplement is the JFS 01137 and is used to collect additional information from child care applicants to determine eligibility for Healthy Start and Healthy Families. The JFS 01137 must be used in conjunction with the JFS 01138 to be considered a complete Medicaid application and must follow application processing procedures as outlined in Ohio Administrative Code (OAC) rule 5101:1-38-01.2, Medicaid: application process.

Language to further support the inclusion of the JFS 01137 will be issued in the OAC rule 5101:1-38-01.2, Medicaid: application process.

This information is also available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpelibility/MEM
MIL 03-005 (MEM)

Medicaid Information Letter: 03-005

April 7, 2003

To: Directors, County Departments of Job and Family Services
From: Rick Keefer, Section Chief
Medicaid Eligibility Policy
Subject: Medicaid Eligibility Manual (MEM)

This letter is to inform County Departments of Job and Family Services that the Medicaid Eligibility Policy Section is redefining how policy is developed and issued. Our goal is to simplify and streamline Medicaid eligibility rules and procedures to enhance the county user's understanding and implementation. The consistent theme for the next year or so will be "change." You will see many modifications to our rule language, rule numbering system, and how we train county staff on this information. In order to make the electronic Medicaid Eligibility Manual utilitarian, we would like these future changes to be viewed as accommodating the needs of the county users.

As you will note, the Medicaid Eligibility Manual was reorganized and issued effective January 3, 2003. One of the major differences with the manual is that all rules are in Ohio Administrative Code format. This format has afforded us the opportunity to group like rules under specific rule numbers. As we continue to review and rewrite our rules, it will be necessary to renumber many of these rules to enhance the number sequence and enable county workers to find rules with greater ease. The electronic version of the manual has even greater enhancements with desk aides and archive functions.

Definitions of the policy letters used to transmit new policy and policy clarifications have been established. The definitions are as follows:

- **Manual Transmittal Letters (MTLs)** are authored by the Medicaid Eligibility Section; they provide a summary of new, revised and/or obsolete policies or rules. MTLs are issued continuously as new regulations, policies and administrative decisions dictate. This letter introduces formal revisions to the Ohio Administrative Code rules and provides instruction of how to maintain the Medicaid Eligibility Manual.

- **Action Change Transmittals (ACTs)** are authored by the Medicaid Eligibility Policy Section to quickly relay policy changes or introduce a special project. ACTs are used when it is required to communicate a change in policy prior to incorporating the change into the Medicaid Eligibility Manual. They are also used to notify of a policy change that does not originate in the department - e.g. federal poverty index. ACTs are considered policy and shall be implemented.

- **Medicaid Information Letters (MILs)** are authored by the Medicaid Eligibility Policy Section and County Oversight and Support Section to provide information or clarification of existing rules and policies. MILs are not policy and do not change or obsolete a rule.

A glossary is being compiled to complement and make consistent the language in the program rules. There will be new rules issued soon that will contain words and definitions not currently being used in the MEM. I am therefore, taking this opportunity to introduce a few of them:

- **Medicaid** will replace current header references instead of "Medicaid and Covered Families and Children Medicaid." There will not be a categorical distinction made, as the program umbrella name is Medicaid.

- **Medical assistance program** will be used if there is a need to distinguish between Medicaid programs based on funding, e.g. Disability Medical Assistance.

- **Administrative agency** is defined as the CDJFS, ODJFS or other entity administering the medicaid program.
This spring will also serve as a time to introduce our new rules training structure. The Medicaid eligibility policy staff will develop training curriculums and provide training and materials to county trainers to train their respective staff. We have attached a list of CDJFS trainers that we plan to use as our county contact around trainings. This list was provided to us by the TOPS program. If you do not have a trainer listed on the attached or would like to add a different or additional trainer, please contact Charlene Alexander in GroupWise at alexac@odjfs.state.oh with the new contact.

Again, we openly solicit your input to help us in the ongoing enhancements of the MEM and thank you for your continued support.

This MIL is available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/oheligibility/MEM

CDJFS Trainers:
Click here to view the list of CDJFS trainers.
We have been notified by the Ohio Department of Aging that effective February 7, 2003, they will no longer be enrolling individuals onto the RSS program until further notice.

Individuals that applied prior to February 7 will continue to have their RSS eligibility explored. The Department of Aging will maintain a waiting list of RSS applicants; therefore, if an individual applies for RSS through the CDJFS, continue to refer the individual to your local Area Agency on Aging or PASSPORT agency.

A CRIS-E View Flash Bulletin will be issued on this subject. If there are any questions regarding a RSS approval, please contact your local AAA or PA.

Thank you.
A new report is available that identifies Medicaid consumers who are (or were) also in receipt of SSI benefits who have entered 1619 status. 1619 status is a work incentive for recipients of SSI who are employed. SSA is responsible for determining 1619 status. In accordance with Medicaid rules 5101:1-39-02.3 and 5101:1-39-10, individuals eligible under 1619 are not required to meet a spenddown regardless of their source(s) of income as long as they remain eligible under the 1619 provisions.

The report is #GDE275RA and is titled "Supplemental Security Income 1619 Incentive Participation." This report will be run on the 5th business day of each month and will be available on the 6th business day. This report is available to individuals who have access to Control D.

Please review this report to identify Medicaid consumers in your county to determine if their 1619 status has been considered in the determination of their Medicaid eligibility.

Within the next several weeks additional information will be available in CRIS-E that will alert caseworkers to individuals who have been identified as enrolled in 1619.
Frequently Asked Questions and Answers:

1. **Since MA S, MA X have been eliminated, can we still earmark child support and ss income when it is for the child?**

   Yes, --basically you should "earmark"/exclude kids out of the group if they have income that affects eligibility for the rest of the AG. Federal Medicaid regulations do not allow for income of a child to be counted against the eligibility of a sibling, nor does it allow for the income of a child to count against the eligibility of a parent [5101:1-40-01.1(B)(4)]. However, the income of a parent (with a few exceptions like SSI) does count toward the eligibility of their child--also the income of a spouse is also counted toward the eligibility of their spouse [5101:1-40-01(J)(4)(a)].

   When you remove a child who has income, you determine the eligibility of the rest of the AG without counting the child's income. To determine the child's eligibility you look at the income of the child and the income of the parent. You do not pro-rate the parent's income but you do allow all of the kids as part of the "headcount" for each assistance group when you are doing Healthy Start. However, if you are doing Healthy Families for the mom and other kids, you use the AG size for those members who are included for Healthy Families benefits.

   It's all about who is financially responsible for whom (parent to child and spouse to spouse) with consideration of the federal restrictions against counting sibling income toward other siblings.

2. **Can we earmark for MA P?**

   Yes, this is the old "headcount" concept. you include the child (sibling/half sibling of other kids in the AG) for "headcount"--ie. household size who is not included for benefits because of income. You include them in the count, but do not include their income--only count mom's income [5101:1-40-01(J)(4)(a)]. When you explore to see if that "earmarked" child is eligible, then you count mom's income (the whole taco), the "earmarked child's income" then allow the other siblings/half-siblings in for "headcount".

3. **Situation:**

   A case consists of husband, wife, common child and the wife's child from a previous father. Husband has earned income and the step-child rec's child support. After allocation of income (5101:1-40-22), only the wife's child is eligible in an MA C. When looking at MA P for the common child, is the need standard of the half-sibling included in the healthystart budget? If so, is this child's child-support income excluded in the MA P since it was used to determine their eligibility in the MA C (i.e. An MA P standard for 4 with only the husband's earned income counted)?

   The financial eligibility for each category is determined independently using the appropriate rules for each category [5101:1-40-01(D)]. When you determine financial eligibility for the common child for Healthy Start you include the stepchild in the household size (i.e. HHS=4) for comparison to the need standard, but exclude the stepchild's income because federal Medicaid policy prohibits deeming of income from siblings unless both siblings are financially eligible within the same AG [5101:1-40-01(J)(4)(a) and 5101:1-40-01.1(B)(4)].

4. **Situation:**
We had a husband and wife, they had a common child and the woman had a child. We pursued MA C for the entire family--it failed due to income. We then created a small MA C for mom and her child and allocated the husbands income. Mom and her child were eligible for MA C. There was then a household change (mom got a job) that made the mom and her child ineligible for MA C. Who is eligible to be included in the MA-Y AG?

It would be proper to put the entire family on the MA Y. This can be done based on 5101:1-40-01(J)(4)(b). In addition, if the natural parent (who is not in the group due to allocated income from the spouse) becomes employed and the earnings cause the child(ren) in the MA C case to lose eligibility, the natural parent can be part of the MA Y if there is a common child, etc. who would be part of a larger MA C at that point, they can also be added to the MA Y.

In an allocation budget--if the individual is determined to be in need, do you count the "allocated income" in the financial determination for the AG?

No. In an allocation budget--if the individual is determined to be in need, the "allocated income" is no longer counted in the financial determination because counting the allocated income would result in prohibited deeming of income [5101:1-40-01(L)(1)(g)].

Shared Parenting:

There needs to be an evaluation on an individual case basis. The county needs to review with the parents the actual arrangements and possibly use information from the school, medical records, etc. to help in the determination. It is suggested that the agency use the criteria listed in 5101:1-3-04.1(c) of the CAM as a guide in making such determinations. The agency should document its decision and afford appeal rights to the appropriate party.

This issue was discussed with CMS (formerly HCFA) eligibility staff in Baltimore--they affirmed the above position and said ultimately the parents may need to declare which parent the kid would be considered to be with for program eligibility purposes. That parent would then also be potentially eligible to be included in the Healthy Families/LIF case--the "noncustodial" parent would not.

The Medicaid Eligibility Policy Section is currently in the process of developing a rule that would address the issue of shared parenting.

Are fugitive felons eligible for Medicaid?

There is no current prohibition against fugitive felons receiving CFC Medicaid. The only mention of the term "fugitive felon" in the MEM is in rule 5101:1-38-02. Although AGs are required to report when an AG member becomes a fugitive felon, there are no consequences to the AG.

Do income changes affect eligibility for the 12 months continuous coverage if a family is receiving Healthy Start Phase 2 with income between 151% and 200% and no creditable insurance?

Under our current rules, income changes do not affect eligibility for the 151-200% group. 5101:1-40-20(E)(2) stipulates that income changes do not affect eligibility of individuals who are currently receiving medicaid under the provisions for uninsured children, as defined in rule 5101:1-40-08 of the Administrative Code, whose family income is from 151%through 200% of the FPL. 5101:1-40-08(C)(6) further stipulates that once determined eligible, uninsured children whose countable assistance group monthly income is more than 150% but not exceeding 200% of the FPL are to receive 12 months continuous coverage unless the child dies, moves out of state or obtains creditable insurance.
(A) This rule contains the definitions of terms used in Chapters 5101:1-37, 5101:1-38, 5101:1-39, 5101:1-40, 5101:1-41, and 5101:1-42 of the Administrative Code. These definitions apply unless a term is otherwise defined in a specific rule.

(B) Definitions.

(1) "Administrative agency" means the CDJFS, ODJFS, or other entity that determines eligibility for a medical assistance program.

(2) "AEMA" means alien emergency medical assistance as established in rule 5101:1-41-20 of the Administrative Code.

(3) "Allocation" and "deeming" mean the distribution of income or resources from a responsible individual not included in the covered group to members of a covered group for whom they have a legal and/or financial responsibility. Allocation or deeming occurs when the responsible individuals are:

   (a) The biological or adoptive parent(s) of an individual; or
   (b) The spouse of an individual.

(4) "Authorized representative" means an individual, eighteen years or older, who stands in place of the individual. The authorized representative may include a legal entity assisting in the application process. The administrative agency may request proper identification from the authorized representative.

(5) "BCCP" means the Ohio breast and cervical cancer project.

(6) "Case record" means electronic or paper documents and information used to determine or redetermine an individual's eligibility for medical assistance.

(7) "CDJFS" means county department of job and family services.

(8) "Child" or "minor child" means a person who has not attained eighteen years of age or has not attained nineteen years of age and is a full-time student in a secondary school or in an equivalent level of vocational or technical training.

(9) "Covered group" means an individual or individuals who qualify for medical assistance under Title XIX or Title XXI of the Social Security Act (as in effect on March 1, 2011).

(10) "CPA" means combined programs application.

(11) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg (a) to (c) (as in effect on February 1, 2010 September 1, 2009).

   (a) This includes:

   (i) A group health plan.

   (ii) Health insurance coverage.

   (iii) Medicare part A, as set forth in 42 U.S.C. 1395c to 1395i-5. (as in effect on February 1, 2010 September 1, 2009) or part B, as set forth in 42 U.S.C. 1395j to 1395w-4 (as in effect on February 1, 2010 September 1, 2009).
(iv) Coverage under medicaid, as set forth in Title XIX of the Social Security Act, other than coverage consisting solely of benefits under the pediatric vaccine program set forth in 42 U.S.C. 1396s (as in effect on February 1, 2010 September 1, 2009).

(v) Armed forces health insurance as set forth in 10 U.S.C. 1071 to 1110a (as in effect on January 7, 2011 September 1, 2009).

(vi) A medical care program of the Indian health service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A federal employee health plan offered under 5 U.S.C. 8901 to 8992 (as in effect on January 7, 2011 September 1, 2009).

(ix) A public health plan.


(b) Creditable insurance does not include:

(i) Coverage only for accident, or disability income insurance.

(ii) Liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance.

(iii) Workers' compensation or similar insurance.

(iv) Automobile medical payment insurance.

(v) Credit-only insurance.

(vi) Coverage for on-site medical clinics.

(vii) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

(viii) Limited-scope dental or vision benefits.

(ix) Benefits for long-term care, nursing home care, home health care, or community-based care.

(x) Coverage only for a specified disease or illness.

(xi) Hospital indemnity or other fixed indemnity insurance, if purchased separately.

(xii) Medicare supplemental health insurance as defined under 42 U.S.C. 1395ss (as in effect on February 1, 2010 September 1, 2009), coverage supplemental to the coverage provided to military or former military personnel under 10 U.S.C. Chapter 55 (as in effect on January 7, 2011 September 1, 2009), and similar supplemental coverage provided to coverage under a group health plan.

(12) "Electronic equivalent" means an electronic version of an ODJFS form or application which has not been modified in any way other than format prior to completion and submission of that form to the administrative agency. The administrative agency is not required to accept forms that are materially altered.

(13) "Electronic signature" has the same meaning as in section 1306.01 of the Revised Code.

(14) "EPSDT" means early and periodic screening, diagnosis and treatment as described in rule 5101:1-38-05 of the Administrative Code, also referred to as healthchek.

(15) "Family" means the following persons living in the same household as the individual for whom medical assistance is sought or received:

(a) The individual;

(b) If the individual is a minor, the biological, adoptive, step parents, or legal guardians, or legal custodians of the individual;
(c) The spouse of any person listed in paragraph (B)(14)(a) (B)(15)(a) or (B)(14)(b) (B)(15)(a) of this rule; and

(d) Minor dependent children of persons listed in paragraph (B)(14)(a) (B)(15)(a), (B)(14)(b) (B)(15)(b), or (B)(14)(c) (B)(15)(c) of this rule.

(16) "FPL" means the federal poverty level determined annually by the office of management and budget as required by 42 U.S.C. 9902(2) (as in effect on February 1, 2010 September 1, 2009).

(17) "Good cause" means circumstances that reasonably prevent an individual from cooperating with the administrative agency in the eligibility determination process. Factors relevant to good cause include, but are not limited to: natural disasters; riots or civil unrest; death or serious illness of the individual or a member of his/her immediate family; or the physical, mental, educational, or linguistic limitations of the individual.

(18) "Home and community-based (HCB) services waiver operational agency" means ODJFS or its designee that performs administrative functions related to an HCB services waiver program in accordance with division 5101:3 of the Administrative Code.

(19) "HCB services" or "HCBS" means specific home and community-based services furnished under the provision of 42 C.F.R. 441, subpart G (as in effect on October 1, 2011 September 1, 2009), that provide specific individuals an alternative to placement in a hospital, a nursing facility (NF), or an intermediate care facility for persons with mental retardation (ICF/MR) as set forth in rule 5101:3-1-06 of the Administrative Code.

(a) HCB services are approved by the federal centers for medicare and medicaid services (CMS) for certain individuals and are not otherwise covered by medicaid. These services may be provided:
   (i) Only in certain areas of the state, and
   (ii) Only to certain individuals.

(b) To receive HCB services, an individual must:
   (i) Be eligible for medicaid; and
   (ii) Apply separately for HCB services; and
   (iii) Be found eligible to receive HCB services.

(20) "Income" is defined in rule 5101:1-38-01.9 of the Administrative Code, means any benefit in cash received by the individual during a calendar month as a result of current or past labor or services, business activities, interests in real or personal property, or as a contribution from persons, organizations, or assistance agencies.

(a) "Countable income", "net countable family income", and "net income" mean the amount of income compared to the appropriate payment or need standard to determine if an individual is eligible for medicaid. After considering allocation and deeming, countable income is then determined by adding all of a family's nonexempt unearned income to nonexempt earned income after subtracting all appropriate disregards.

(b) "Earned income" means payment received by an individual for services performed as an employee or as a result of the individual being engaged in self-employment or as a result of providing room and board or board, including salary, wages, royalties, honoraria, or "net earnings from self-employment" as defined in rule 5101:1-39-15 of the Administrative Code.

(c) "Gross income" means all nonexempt earned or unearned income.

(d) "Unearned income" means all income that is not earned income.

(21) "Individual" means an applicant for or recipient of a medical assistance program.
"Institution for mental diseases" (IMD) means a hospital, nursing facility, or other institution of more than sixteen beds primarily providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

(a) A facility established and maintained primarily for the care and treatment of individuals with mental diseases is an IMD, whether or not it is licensed as such.

(b) An institution for persons with mental retardation is not an institution for mental diseases.

"LIF" means low-income families medicaid under section 1931 of the Social Security Act.

"Limited English proficiency" (LEP) means any person or group of persons who cannot speak, read, write or understand the English language at a level that allows them to meaningfully communicate with county agencies or county agency contractors.

"Medicaid eligibility fraud" means a violation of section 2913.401 of the Revised Code, which states that no person, in an application for medicaid benefits or in a document that requires a disclosure of assets for the purpose of determining eligibility to receive medicaid benefits, shall knowingly:

(a) Make or cause to be made a false or misleading statement; or

(b) Conceal an interest in property; or

(c) Fail to disclose a certain transfers of property.

"Medical assistance program" includes all programs administered by the state medicaid administrative agency.


"Non-cooperation" or "failure to cooperate" means failure by an individual to present required verifications, or to explain why it is not possible to present the verifications, after being notified the verification was required for eligibility determination.

"ODJFS" means the Ohio department of job and family services.

"PCPA" means a private child placing agency.

"PCSA" means a public children services agency.

"Pend" or "pending" means the administrative agency has begun to process an individual's application for medical assistance but has not yet determined whether an individual is eligible for a category of medical assistance.

"Personal knowledge" means first-hand knowledge of circumstances of an event. A person verifying an event, based on personal knowledge, should be able to share such details as when and where the event occurred, who was involved and whether there were any special circumstances surrounding the event.

"Postpartum coverage" means a span of medicaid eligibility beginning on the last day of a pregnancy (if the woman was eligible for and receiving medicaid on that date) and ends on the last day of the month in which the sixtieth day (after the last day of the woman's pregnancy) falls.

"PTR" means pre-termination review as set forth in rule 5101:1-38-01.2 of the Administrative Code. This is done prior to any termination of assistance to determine whether a consumer is eligible for any other category of assistance.

"Redetermination" means a review to determine whether the individual continues to meet all of the eligibility requirements of the medical assistance category. A redetermination is performed periodically or when information about possible changes to an individual's eligibility is received by the administrative agency.
"Reporting" means notifying the administrative agency of any changes that may affect an individual's eligibility for medical assistance. Reporting changes and providing verifications is the responsibility of any individual, person, or entity who has a legal or financial responsibility for or who stands in the place of an individual, including:

(a) The individual;
(b) The individual's spouse, including a community spouse;
(c) The individual's parent, guardian, or specified relative; and
(d) The individual's authorized representative.

"Residence" means the place the individual considers his or her established or principal home and to which, if absent, he or she intends to return.

"Residential care facility" (RCF) means a home that provides either of the following:

(a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment; or
(b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals, any of the skilled nursing care authorized by section 3721.011 of the Revised Code.

"Self-declaration" means a statement or statements made by an individual.

"Specified relative" means the following individuals who are age eighteen or older:

(a) The following individuals related by blood or adoption:
   (i) Grandparents, including grandparents with the prefix great, great-great, or great-great-great;
   (ii) Siblings;
   (iii) Aunts, uncles, nephews, and nieces, including such relatives with the prefix great, great-great, grand, or great-grand; and
   (iv) First cousins and first cousins once removed.
(b) Step parents and stepsiblings;
(c) Spouses and former spouses of individuals named in paragraph (B)(40)(a) (B)(41)(a) or (B)(40)(b) (B)(41)(b) of this rule.

"SSA" means the social security administration.

"SSN" means social security number.

"Suspend" or "suspended" means the temporary closing or terminating of eligibility.

"Temporary absence" means that an individual (parent or child) who is otherwise considered part of the family is considered to be temporarily absent (and not to have changed residence) when all of the following conditions are met:

(a) The location of the absent individual is known;
(b) There is a definite plan for the return of the absent individual to the family's place of residence; and
(c) The absent individual shared the place of residence with the family immediately prior to the absence, except for individuals described in paragraph (B)(7) (B)(6) of rule 5101:1-40-02.2 of the Administrative Code.
(d) Child(ren) removed by the PCSA are considered temporarily absent as long as they meet the reunification requirements specified in the reunification plan.

(46) “Terminate” or “terminated” means a determination by the administrative agency that an individual is no longer eligible, or has failed to cooperate with verification of eligibility, for one or more categories of assistance currently being received by that individual, resulting in a written notice of the administrative agency’s intention to cease coverage under that category and providing notice of hearing rights as required by 42 C.F.R. 435.919 (as in effect on October 1, 2011 September 1, 2009).

(47) “United States (U.S.)” and “state(s)” means all fifty U.S. states, the District of Columbia, and the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, Swain’s Island and the U.S. Virgin Islands.

(48) “United States citizen or national” means any individual who is:

(a) A citizen or national through birth or collective naturalization as set forth in 8 U.S.C. Chapter 12, Subchapter III, Part I (as in effect on January 7, 2011 September 1, 2009); or

(b) A naturalized citizen or national as set forth in 8 U.S.C. Chapter 12, Subchapter III, Part II (as in effect on January 7, 2011 September 1, 2009).

(49) “Verification” means a document or statement from a third party or collateral contact confirming statements made by the individual about a specific eligibility criterion. A verification document or written statement may be an original, photocopy, facsimile (fax), or electronic version of the original, unless otherwise stated.

Effective:
R.C. 119.032 review dates: 10/01/2014
Certification
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011
Rule Amplifies: 5111.01, 5111.011, 5101.58
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MEMTL 94

Effective Date: January 15, 2015

(A) This rule describes the requirements in section 1137 of the Social Security Act (as in effect on May 1, 2014) and in section 42 C.F.R. 435.945 (as in effect on May 1, 2014), requiring state agencies administering certain federally funded, state administered public assistance programs, to establish procedures for obtaining, using and verifying information relevant to determinations of eligibility. The Ohio department of medicaid shall obtain and share income and benefit information with the following sources:

1. The social security administration (SSA).
2. The internal revenue service (IRS).
3. The state wage information collection agency (SWICA).
4. The agencies administering the State unemployment compensation (UC) laws.

(B) Definition. "IEVS" is defined in rule 5160:1-1-50.1 of the Administrative Code.

(C) Administrative agency responsibilities. The administrative agency shall:

2. Inform all individuals in writing at the time of application and reapplication that the agency will obtain and use information available from IEVS to verify an individual's eligibility for medicaid.
3. Within forty-five days of receipt of the information, review and compare against the case record all information received to determine whether it affects the individual's eligibility. Obtain verification, if appropriate, to determine eligibility and initiate appropriate action in accordance with 42 C.F.R. 435.952(c) (as in effect on May 1, 2014). For applicants, if the information is received during the application period, it must be used to the extent possible to make eligibility determinations, in accordance with 42 C.F.R. 435.952(b) (as in effect on May 1, 2014).
4. Verify the information, in accordance with 42 C.F.R. 435.948 (as in effect on May 1, 2014) and 42 C.F.R. 435.949 (as in effect on May 1, 2014).
5. Not terminate, deny, suspend benefits until appropriate steps have been taken to verify the information in accordance with 42 C.F.R. 435.952(d) (as in effect on May 1, 2014). The administrative agency shall verify information relating to:
   a. The amount of the income and resource involved;
   b. Whether the individual actually has or had access and use of the resource, income, or both;
   c. The period of time during which the individual actually has or had access to the resource, income, or both.
6. Maintain the individual's data in a standardized format that allows the administrative agency to furnish and to obtain eligibility and income information from the agencies or programs referenced in 42 C.F.R. 435.945 and 42 C.F.R. 435.948(a) in accordance with 42 C.F.R. 435.960(a) (as in effect on May 1, 2014).
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 1/1/83, 12/1/86, 3/13/87 (Emer.), 5/4/87, 9/1/89 (Emer.), 11/30/89, 1/1/90 (Emer.), 4/1/90, 1/1/93, 9/1/94, 11/1/96, 7/1/98, 7/1/99, 10/1/02, 10/06/03, 11/1/09
Effective Date: January 9, 2012

(A) This rule sets forth guidelines for general income, exemptions and disregards applying to all medicaid covered groups for determining eligibility. Income guidelines that apply to a specific covered group will be addressed in that specific covered group’s rule.

(1) Unless otherwise stated, income and resources of a spouse are considered available to the other spouse, and income and resources of a parent are considered available to children under age twenty-one.

(2) The administrative agency shall count as income to the covered group the income, after appropriate exemptions and disregards, of a minor’s own parent(s) living in the same household as the minor and the minor’s dependent child.

(B) Definitions.

(1) "Deduction" means a verifiable amount the individual pays for an expense. It is subtracted, after any income disregards, from the medicaid eligibility budget.

(a) Up to a specified maximum amount, the actual amount paid, including cents, is disregarded.

(b) Garnishments or liens placed against earned or unearned income of an individual are not considered a deduction, regardless of the reason for the garnishment or lien.

(2) "Disregard" means the amount subtracted from gross non-exempt income in the medicaid eligibility budget.

(3) "Earned income" means gross income in cash or in kind, prior to any deductions received as payment for services performed as an employee or as a self-employed individual. Earned income includes but is not limited to wages, salary, commissions, or "net income from self-employment" from which state or federal income and payroll taxes are paid or withheld.

(4) "Exempt income" means income that state or federal law prohibits from consideration in determining medicaid eligibility.

(5) "Gross, non-exempt income" means any income that is not exempt income.

(6) "Gross countable income from self-employment" means the gross income from a business minus the expenses directly related to producing the goods or services, and without which the goods or services could not be produced. For self-employed home day-care providers, it is fifty per cent of the provider’s gross income or the gross income minus verifiable actual operating expenses.

(a) If the individual has filed taxes for the previous year, use all tax forms that were filed with the internal revenue service (IRS).

(b) If the individual has not filed taxes for the previous year, the following may be used:

(i) Business records including receipts for the costs of doing business, or

(ii) Estimated net income.

(c) Items that cannot be used as expenses for the purpose of determining medicaid eligibility include depreciation, personal business and entertainment expenses, personal transportation, purchase of capital equipment and payments on the principal of loans for capital assets or durable goods.

(7) "Home produce" means farm and garden produce grown by the individual or family.
(8) "Income" means any benefit in cash or in-kind, received by an individual during a calendar month.

(9) "In-kind" means any benefit received other than cash.

(10) "Lump-sum" means a non-recurring payment made, in a single amount, as opposed to smaller payments over time. A lump-sum payment is considered unearned income, unless otherwise exempted, in the month received.

(11) "Net countable family income" means the amount of income remaining after any appropriate exemptions, disregards, or deductions are applied.

(12) "Non-exempt income" means income (earned and unearned) that is not exempt.

(13) "Unearned income" means all income that is not earned income.

(C) Calculating monthly income. The amount of gross monthly non-exempt income must be established first. Disregards and deductions, when applicable, will then be subtracted.

(1) Determining the gross monthly income (earned and unearned). The amount shall be rounded down by dropping the cents.

(2) To correctly calculate income that is not received on a monthly basis, use the following conversion factors:

(a) Income received weekly shall be multiplied by 4.3.

(b) Income received bi-weekly (every two weeks) shall be multiplied by 2.15.

(c) Income received semi-monthly (twice a month) shall be multiplied by 2.0.

(d) Gross annual income received shall be divided by 12.0.

(e) For contract employees, divide the gross payment amount by the number of calendar months the contract covers. This also applies when a one-time payment is made for work that is done over a period.

(D) Exempt income. The administrative agency shall exempt the following:

(1) Grants, loans, and/or scholarships to any undergraduate student for educational purposes made or insured under any programs administered by the secretary of education.

(a) Student financial assistance provided by the Perkins loan will be exempt only when the funds are used for the following attendance costs:

(i) Tuition, fees, book, and supplies normally assessed by the institute of higher education.

(ii) Costs for rental or purchase of equipment, materials or supplies required by students in the same course of study. This can also include transportation and dependent care for a student attending at least half-time as determined by the institution.

(b) Grants or loans to any undergraduate student for educational purposes made or insured under any programs administered by the secretary of education under section 507 of the Higher Education Amendments of 1968.

(c) Any student financial assistance provided under programs in title IV of the Higher Education Act of 1965, as amended, and under bureau of Indian affairs education assistance programs.

(2) Home produce of an individual, utilized by the individual and the household for consumption.

(3) Income tax refunds.

(4) Small, non-recurring gifts, not to exceed thirty dollars per quarter.

(5) SSI payments.
(6) Residential state supplement (RSS) payments.

(7) Federal, state, and local foster care payments received under title IV-E, for a child currently living in the household.

(8) Federal, state, and local adoption assistance payments received under title IV-E.

(9) The value of foods donated by the U.S. department of agriculture (surplus commodities).

(10) Any relocation assistance paid by a public agency to a public assistance recipient, who has been relocated as a result of redevelopment, urban renewal, freeway construction, or any other public development involving condemnation or demolition of the existing residence.

(11) Payments for supporting services or reimbursement of out-of-pocket expenses to volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the service corps of retired executives (SCORE), active corps of executives (ACE), and any other programs under 42 U.S.C 5044 (as in effect February 1, 2010).

(12) Payments to individuals participating in the volunteers in service to america (VISTA) program and any other program under Section 404, 42 U.S.C. 5044 (as in effect February 1, 2010) so long as the amount does not exceed the equivalent of state or federal minimum wage, whichever is higher.

(13) The value of supplemental food assistance received under the Child Nutrition Act of 1966 described in 42 U.S.C. 1771 (as in effect February 1, 2010) and the special food service program for children under the national school lunch act described in 42 U.S.C. 1751 (as in effect February 1, 2010).

(14) Any of the following distributions made to a household, an individual native, or a descendant of a native by a native corporation established pursuant to the Alaska Native Claims Settlement Act (ANCSA), section 3, 43 U.S.C. 1602 (as in effect February 1, 2010):
   (a) Cash distributions (including dividends on stock from a native corporation) received by an individual up to two-thousand dollars per year.
   (b) Stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock).
   (c) A partnership interest.
   (d) Land or an interest in land (including that received from a native corporation as a dividend or distribution on stock).
   (e) An interest in a settlement trust.


(16) Any funds and judgment funds distributed per capita or held in trust for members of the Blackfoot and Grosventre Tribes under Pub. L. 92-254 or the Grand River Band of Ottawa Indians under Pub. L. 92-540, up to two-thousand dollars per individual per year.


(18) Indian judgment funds held in trust by the secretary of the interior (including interest and investment income accrued while funds are held in trust), or distributed per capita to a household or a member of an Indian tribe pursuant to a plan prepared by the secretary of the interior and not disapproved by a joint resolution of the congress, and any initial purchases made with these funds in accordance with 25 U.S.C. 1407 (as in effect January 7, 2011).

(19) All funds held in trust by the secretary of the interior for an Indian tribe (including interest and investment income accrued while funds are held in trust) and distributed per capita to a household or member of an Indian tribe, and initial purchases made with the funds in accordance with Section 2, 25 U.S.C. 117b (as in effect January 7, 2011).
The exemptions in paragraph (D)(18) and (D)(19) of this rule do not apply to:

(a) Proceeds from the sale of initial purchases.

(b) Subsequent purchases made with funds derived from the sale or conversion of initial purchases.

(c) Funds or initial purchases which are inherited or transferred.

Payments received on or after January 1, 1989, as a result of the Agent Orange Compensation Exclusion Act (Pub. L. 101-201).

Restitution payments under the Civil Liberties Act of 1988, to U.S. citizens of Japanese ancestry and permanent resident Japanese non-citizens who were interned during World War II, or their survivors, section 105, 50 U.S.C. 1989b (as in effect February 1, 2010).

Restitution payments for Aleutian and Pribilof Island Restitution Act under section 206, 50 U.S.C. 1989c (as in effect February 1, 2010).

Payments under the Radiation Exposure Compensation Act, 42 U.S.C. 2210 (as in effect February 1, 2010)

Earned income tax credit payments in the form of a refund of federal income tax or in the form of an advance payment by an employer.

Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. 111).

Payments to victims of Nazi persecution.

Principal of a bona-fide loan.

Exemptions of income from paragraphs (D)(16) to (D)(28) of this rule do not apply to interest earned on these funds. Any interest earned is counted as unearned income in the month received and a resource thereafter.

Any federal major disaster and emergency assistance described in 42 U.S.C. 5170 (as in effect on February 1, 2010), including comparable disaster assistance provided by states, local governments and disaster assistance organizations.

Nutrition program benefits provided for the elderly under Title VII of the Older Americans Act of 1965, as amended.

Housing and urban development (HUD) payments covering rent and utility bills which do not exceed the twenty-five per cent payment limitations stipulated by the Brooke Amendment of 1987.

Retroactive payments paid to the individual as the result of a state hearing.

Retroactive payments paid as a result of reconsideration of SSI benefits.

Experimental housing allowance program payments made under annual contributions contracts entered into prior to January 1975, as described in 42 U.S.C. 1437 (as in effect February 1, 2010).

Payments to crime victims from a federal or federally funded state or local program including Washington state crime victims compensation program under title XXIII of the Violent Crime Control and Law Enforcement Act of 1994.

Effective March 1, 1995, basic health insurance, child care or child care allowances, auxiliary aid and services for disabled individuals and the national service educational award provided for individuals participating in a national service program established under the National and Community Services Trust Act of 1993. Payments received as a living allowance are considered income.

Income disregards. The administrative agency shall disregard the following:
Fifty per cent of a home daycare provider's gross earned income.

Income received for temporary employment with the census bureau, related to the ten-year census. Interest received from these funds is not disregarded.


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R.C. 119.032 review dates: 01/01/2017
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Date: 12/30/2011
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MEMTL 95

Effective Date: January 15, 2015

(A) This rule describes Ohio's medicaid estate recovery program and the undue hardship waiver request process.

(B) Definitions.

(1) "Estate" includes both of the following:

   (a) All real and personal property and other assets to be administered under Title XXI of the Revised Code and property that would be administered under that title if not for section 2113.03 or 2113.031 of the Revised Code; and

   (b) Any other real and personal property and other assets in which an individual had any legal title or interest at the time of death (to the extent of the interest), including assets conveyed to a survivor, heir, or assign of the individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(2) "Home" is defined in rule 5160:1-3-05.13 of the Administrative Code.

(3) "Individual," for the purpose of this rule, means someone with past or current medicaid eligibility.

(4) "Permanently institutionalized individual" is defined in section 5162.21 of the Revised Code.

(5) "Person responsible for the estate" is defined in section 2117.061 of the Revised Code.

(6) "Personal property" means any property that is not real property. The term includes, but is not limited to, such things as cash, jewelry, household goods, tools, life insurance policies, automobiles, promissory notes, etc.

(7) "Qualified long-term care partnership (QLTCP)" is defined in rule 5160:1-3-02.8 of the Administrative Code.

(8) "Real property" means land, including buildings or immovable objects, attached permanently to the land.

(9) "Time of death" is defined in section 5162.21 of the Revised Code.

(C) The Ohio attorney general (AGO) will seek recovery or adjustment, on behalf of the Ohio department of medicaid (ODM), from the estates of the following individuals:

   (1) A permanently institutionalized individual of any age, in the amount of all medicaid benefits correctly paid; or

   (2) An individual fifty-five years of age or older who is not permanently institutionalized, in the amount of all medicaid benefits correctly paid (other than benefits paid on or after January 1, 2010, under the medicare premium assistance programs set forth in rules 5160:1-3-02.6 and 5160:1-3-02.1 of the Administrative Code) after the individual attained such age.

(D) Any adjustment or recovery under paragraph (C) of this rule may be sought only:

   (1) After the death of the individual's surviving spouse, if any; and

   (2) When the individual has no surviving child who either is under age twenty-one or is blind or permanently and totally disabled as defined in Chapter 5160:1-3 of the Administrative Code; and

   (3) If recovery is sought against a permanently institutionalized individual under paragraph (C)(1) of this rule, no recovery may be made against the individual's home while either of the following lawfully resides in the home:

      (a) The permanently institutionalized individual's sibling who:

         (i) Resided in the home for at least one year immediately before the date of the individual's admission to the institution, and
(ii) Has resided in the home on a continuous basis since that time.

(b) The permanently institutionalized individual's son or daughter who:

(i) Provided care to the permanently institutionalized individual that delayed the individual's institutionalization, and

(ii) Resided in the home for at least two years immediately before the date of the individual's admission to the institution, and

(iii) Has resided in the home on a continuous basis since that time, and

(iv) Documents that he or she has fulfilled these requirements by submitting the following:

(A) A written statement of the date that he or she moved into the home;

(B) A level of care assessment showing that the individual would have become institutionalized earlier without care provided by the adult son or daughter;

(C) A written statement from the individual's attending physician, stating the kind and duration of care that was required to delay the individual's institutionalization; and

(D) All relevant documentation of the care that delayed institutionalization and the role the adult son or daughter played in that care. This documentation shall include (but is not limited to) one or more of the following:

(i) A written statement of the number of hours per day during which the adult son or daughter provided personal care, specifying the extent and type of care provided;

(ii) A written statement of any part-time or full-time jobs performed by the adult son or daughter, and any schools or other similar institutions attended by the adult son or daughter, while providing care; or

(iii) Written documentation from a service agency which provided care to the individual, the dates on which care was provided, and the extent and type of care provided.

(E) Notice requirements.

(1) When an individual was age fifty-five or older or was permanently institutionalized at the time of death, the person responsible for the estate must give notice to the AGO, as required by section 2117.061 of the Revised Code.

(2) After the individual's death, whenever adjustment or recovery is sought by ODM or its designee, a claim for recovery must be presented by the AGO.

(a) The claim must include all information required by Chapter 2117. of the Revised Code and must be served on the person responsible for the estate or, if there is no person responsible for the estate, any person who received or controls probate or non-probate assets inherited from the individual.

(b) The claim must include the following:

(i) That this rule defines undue hardship in paragraph (H) of this rule, and sets out the process for requesting an undue hardship waiver in paragraph (I) of this rule;

(ii) What form (as specified by the ODM director) must be completed to request an undue hardship, and where that form can be obtained; and

(iii) The date by which that form must be submitted in order to request an undue hardship waiver.
The person responsible for the estate shall notify any person who received or controls probate or non-probate assets, inherited from the individual, affected by the proposed recovery.

If the person responsible for the estate from which recovery is sought requests to satisfy the claim without selling a non-liquid asset subject to recovery, the AGO may establish a payment schedule, promissory note, or lien.

Qualified long-term care partnership disregard.

1. The amount of resources disregarded at eligibility determination (as established in rule 5160:1-3-02.8 of the Administrative Code) will be disregarded during estate recovery.

2. The following resources, which are not considered a resource at eligibility determination, will not be disregarded during estate recovery:
   a. Special needs trusts as established in rule 5160:1-3-05.2 of the Administrative Code;
   b. Pooled trusts as established in rule 5160:1-3-05.2 of the Administrative Code; and
   c. Annuities as described in rule 5160:1-3-05.3 of the Administrative Code.

3. The QLTCP disregard at estate recovery is reduced to the extent that an individual made a transfer (that would otherwise have been considered an improper transfer under rule 5160:1-3-07.2 of the Administrative Code) without a restricted medicaid coverage period.

The ODM director, or designee, may grant an undue hardship waiver on a case-by-case basis when there are compelling circumstances.

1. ODM may, at the sole discretion of the ODM director or the director's designee, waive estate recovery when recovery would work an undue hardship on an individual's survivors. Undue hardship may be found in the following cases.
   a. The estate subject to recovery is the sole income-producing asset of the survivor, such as a family farm or other family business, which:
      i. Produces a limited amount of income, or
      ii. Is the sole asset of the survivor.
   b. Without receipt of the estate proceeds, the survivor would become eligible for public assistance.
   c. Recovery would deprive the survivor of necessary food, shelter or clothing. Deprivation does not include situations in which the survivor is merely inconvenienced but would not be at risk of serious harm.
   d. The survivor provides clear and convincing evidence of substantial personal financial contributions to the deceased individual, creating an equity interest in the property.
   e. The survivor is age sixty-five or older and financially dependent upon receipt of the estate proceeds.
   f. The estate proceeds are preserved for the benefit of a survivor who:
      i. Is totally and permanently disabled as defined in Chapter 5160:1-3 of the Administrative Code; and
      ii. Is financially dependent upon receipt of the estate proceeds.

2. The following situations do not, without additional showing of hardship, show undue hardship:
   a. When recovery will prevent heirs from receiving an anticipated inheritance.
   b. When recovery results in the loss of a pre-existing standard of living, or prevents the establishment of a source of maintenance that did not exist prior to the individual's death.

3. Regardless of actual hardship, an undue hardship waiver will not be granted in the following situations:
(a) When the individual created the hardship by using estate planning methods under which
the individual divested, transferred, or otherwise encumbered assets in whole or in part to
avoid estate recovery.

(b) When an undue hardship waiver will result in the payment of claims to other creditors
with lower priority standing under Ohio's probate law.

(I) Request for undue hardship waiver.

(1) Within thirty calendar days after notice of the estate recovery claim was mailed by the AGO, an
undue hardship waiver may be requested (upon such form as may be designated by the ODM
director) by an heir or potential heir who would suffer an undue hardship if a waiver is not
granted, a person with an interest in assets of the estate, or a representative of such persons.
An undue hardship waiver may not be requested by a creditor of the estate, unless such creditor
is also a potential heir of the estate.

(2) Within sixty calendar days of receipt of the request for an undue hardship waiver, ODM must
notify the applicant whether the waiver request has been approved (in full, in part, or for a
limited time) or denied. Failure to meet this sixty day deadline does not result in an automatic
decision on the request.

(3) If the waiver request was not approved in full, or if the approval was time-limited, the applicant
may, within thirty calendar days, request (on such form as the director designates) that the ODM
director, or designee, review the undue hardship waiver decision.

(a) The ODM director, or designee, will review only those portions of the undue hardship
waiver request that were denied or time-limited. The director will not deny or limit any
portion of the undue hardship waiver request that has already been granted.

(b) The ODM director, or designee, must review the undue hardship waiver request and
notify the applicant within sixty calendar days whether (at the director's sole discretion)
the director, or designee, has approved (in full, in part, or for a limited time) or denied the
request for an undue hardship waiver. Failure to meet this sixty day deadline does not
result in an automatic decision on the request.

(J) Within thirty days after notice of the estate recovery claim was mailed by the AGO, a person with an
interest in assets of the estate (or a representative of any such person) may (upon such form as may
be designated by the ODM director) present a claim showing evidence that assets of the estate are
exempt assets under one of the following categories.

(1) Government reparation payments to special populations are exempt from medicaid estate
recovery.

(2) Certain American Indian and Alaska native income and resources, including:

(a) American Indian and Alaska native income and resources which are exempt from
medicaid estate recovery by other laws and regulations;

(b) Ownership interest (when ownership would pass from an Indian to one or more relatives;
to a tribe or tribal organization; and/or to one or more Indians) in trust or non-trust
property, including real property and improvements:

(i) Located on a reservation (any federally recognized Indian tribe's reservation,
pueblo, or colony, including former reservations in Oklahoma, Alaska native
regions established by Alaska native claims settlement act and Indian allotments)
or near a reservation as designated and approved by the bureau of Indian affairs
of the U.S. department of the interior; or

(ii) For any federally-recognized tribe not described in paragraph (J)(2)(b)(i) of this
rule, located within the most recent boundaries of a prior federal reservation; or

(c) Income left as a remainder in an estate derived from property protected in paragraph
(J)(2)(b) of this rule, that was either collected by an Indian, or by a tribe or a tribal
organization and distributed to an Indian, as long as the income clearly comes from protected sources;

(d) Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a tribe or tribal organization and distributed to an Indian derived from these sources the income or ownership interest clearly comes from protected sources; and

(e) Ownership interests in or usage rights to items that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

Replaces: 5160:1-2-10
Effective: 01/15/2015
Five Year Review (FYR) Dates: 01/15/2020
Certification: CERTIFIED ELECTRONICALLY
Date: 01/05/2015
Promulgated Under: 111.15
Statutory Authority: 5162.21
Rule Amplifies: 5162.21, 5162.211, 5162.23, 5164.86
Prior Effective Dates: 7/1/00, 9/1/07, 1/1/10
This rule sets forth the process for determining whether an individual is eligible for medicaid payments for services under the HCB services waivers set out in Agency 5160 of the Administrative Code.

Eligibility for HCB services. To receive HCB services, the individual shall:

1. Be in receipt of medicaid, as described in Chapters 5160:1-1 to 5160:1-5 of the Administrative Code;
2. Be in need of HCB services under a waiver described in Agency 5160 of the Administrative Code; and
3. Be enrolled in an HCB services waiver described in Agency 5160 of the Administrative Code.

Determination of eligibility for HCB services. The administrative agency shall approve HCB services for an individual in receipt of medicaid only upon:

1. Approval by the HCB services waiver operational agency, as defined in 5160:1-1-50.1 of the Administrative Code; and
2. If services under the waiver are available only to a specific number of individuals, notification that the individual may be enrolled in the waiver from the Ohio department of medicaid (ODM), its designee, or a HCB services waiver operational agency.

Coverage period. The HCB services coverage period can have a different beginning date or ending date from the medicaid eligibility period.

1. HCB services cannot:
   a. Begin before an individual's medicaid eligibility period or before an individual's retroactive medicaid eligibility period;
   b. Extend beyond the termination date of an individual's medicaid coverage; and
   c. Be provided during any period of medicaid ineligibility.

Medicaid coverage of HCB services begins on the latest of the following dates:

1. The date the administrative agency receives a signed application for HCB services from an individual; or
2. The signature date, if the administrative agency receives a signed and dated HCB services application from a waiver operational agency no more than five working days after the date of signature; or
3. The date the administrative agency receives the signed application for HCB services, if the application was received from a HCB services waiver operational agency more than five working days after the date of signature.

Medicaid coverage of HCB services terminates when either:

1. The administrative agency determines the individual no longer meets medicaid conditions of eligibility as described in rule 5160:1-1-58 of the Administrative Code or the criteria for coverage of HCB services; or
The HCB services waiver operational agency notifies the administrative agency that it no longer authorizes the individual to receive its HCB services.

HCB services waiver operational agency responsibilities. HCB services waiver operational agencies shall:

1. Submit an ODM 02399 "Request for Medicaid Home and Community-Based Services (HCBS)" (rev. 7/2014), signed by the individual, to the administrative agency within five days of the signature date, if assisting an individual with an application for HCB services.

2. Determine, in accordance with this rule and Agency 5160 of the Administrative Code, whether the individual requesting medicaid coverage of HCB services meets the requirements of the applicable HCB services waiver program.

3. Provide written notification of determinations to individuals, including to whom any patient liability must be paid, if applicable.

4. Notify the administrative agency of determinations and subsequent changes regarding approval of HCB services.

Administrative agency responsibilities. The administrative agency shall:

1. Determine an individual's eligibility for HCB services in accordance with this rule and Chapters 5160:1-1 to 5160:1-5 of the Administrative Code.

   a. If an individual who applies for HCB services is currently in receipt of medicaid, the administrative agency shall process the individual's application for HCB services.

   b. If an individual who applies for HCB services is not currently in receipt of medicaid, the administrative agency shall begin the application process described in rule 5160:1-1-51 of the Administrative Code.

   c. If the administrative agency determines that an individual who applies for HCB services is not eligible for any category of medical assistance, the administrative agency shall deny both medical assistance and HCB services for that individual.

2. Notify the applicable HCB services waiver operational agency, within five days of the receipt of a signed ODM 02399, via the electronic eligibility system of the receipt of the application. If the HCB services waiver operational agency is not known or if multiple waiver agencies are indicated on the application, the administrative agency shall submit the ODM 02399 to ODM.

3. Notify the applicable HCB services waiver operational agency of changes in the individual's eligibility for medicaid coverage of HCB services.

Replaces: 5160:1-2-01.6
Effective: 03/23/2015
Five Year Review (FYR) Dates: 03/23/2020
Certification: CERTIFIED ELECTRONICALLY
Date: 03/12/2015
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02, 5166.20, 5166.21
Rule Amplifies: 5160.02, 5163.02, 5166.21, 5162.35
Prior Effective Dates: 6/1/88 (Emer.), 8/1/88 (Emer.), 10/30/88, 1/1/90 (Emer.), 3/1/90 (Emer.), 3/30/90 (Emer.), 4/1/90, 6/29/90, 7/1/90, 10/1/90, 1/1/91 (Emer.), 4/1/91, 1/1/92 (Emer.), 3/20/92, 3/30/92, 5/1/92 (Emer.), 7/1/92, 8/14/92 (Emer.), 1/1/92, 5/1/93, 9/1/93, 7/1/94, 10/1/02, 10/1/04, 10/1/09
Chapter 3 \ Aged, Blind, and Disabled (ABD)
MEMTL 90

**Effective Date: January 22, 2015**

(A) The medicaid program provides coverage for individuals who meet the aged, blind, or disability status as set forth in the Social Security Act. The provisions of Chapter 5160:1-3 of the Administrative Code establish eligibility criteria, standards, and procedures that apply to the following groups of individuals:

1. Individuals enrolled in an aged, blind or disability categorical coverage group, and
2. Where specified in rule, individuals who are enrolled in the medicaid expansion group described in the Social Security Act section 1902(a)(10)(A)(i)(VIII) (as in effect March 1, 2014), but who could have qualified in an aged, blind or disability categorical coverage group under eligibility standards in effect in Ohio on December 1, 2009.

(B) The rules of this chapter are organized as follows:

1. Rules under principal rule number 5160:1-3-02 set forth base eligibility requirements of the aged, blind, or disabled eligibility covered groups.
2. Rules under principal rule number 5160:1-3-03 set forth income eligibility requirements.
3. Rules under principal rule number 5160:1-3-04 set forth eligibility processes and standards relating to spenddown, patient liability and special income level.
4. Rules under principal rule number 5160:1-3-05 set forth resource eligibility requirements.
5. Rules under principal rule number 5160:1-3-06 set forth standards for cases involving a community spouse and institutionalized spouse.
6. Rules under principal rule number 5160:1-3-07 set forth standards for cases involving improper transfers of resources or income.

Effective: 01/22/2015

Five Year Review (FYR) Dates: 01/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/12/2015

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02
MEMTL 90

Effective Date: January 22, 2015

(A) The medicaid program provides coverage for individuals who have been determined to meet the criteria for the limiting physical factors of age, blindness, or disability as set forth in the Social Security Act. Age is determined by county departments of job and family services (CDJFS). Blindness and disability are determined by either the social security administration (SSA) or the Ohio department of medicaid (ODM). The criteria are as follows:

1. Age: A person who is age sixty-five years or older meets the age requirement for medicaid. Verification of age is required.

2. Blindness: A person is considered to be blind if he or she has central visual acuity of 20/200 or less in the better eye with correcting glasses, or a limited visual field of twenty degrees or less in the better eye. A person determined to be blind for purposes of supplemental security income (SSI) benefits also qualifies as blind for purposes of medicaid.

3. Disability.
   a. Disability is defined differently for adults and children. An individual is disabled if the individual is:
      i. An adult who is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.
      ii. A child under the age of eighteen who has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than twelve months. No individual under the age of eighteen who engages in substantial gainful activity may be considered disabled.
   b. An individual shall be considered to be disabled under one of the following criteria:
      i. An individual who has been determined disabled by SSA for purposes of SSI or social security disability insurance (SSDI) benefits.
      ii. An individual who meets one of the presumptive disability criteria listed in paragraph (E) of this rule.
      iii. An individual who has been determined disabled by ODM and, subject to the limitations set forth in paragraph (B) of this rule, has an SSI claim pending.

(B) All individuals who are seeking medicaid eligibility based on their own age, blindness or alleged disability must also apply for SSI or retirement, survivors and disability insurance (RSDI) and have their eligibility for SSI or RSDI determined. If an individual has been determined to meet the limiting physical factor criteria based on age, blindness, disability or the receipt of RSDI, a referral to SSI must be made only when the individual's countable income is less than the current SSI federal benefit rate (FBR).

1. If the applicant has been determined by SSA to be eligible for SSI or RSDI disability benefits based on his or her own age, blindness or disability, the limiting physical factor is met and no further referral is necessary.

2. An individual who receives a final decision from SSA denying SSI or RSDI for lack of a physical or mental disability does not meet the limiting physical factor criteria for medicaid.

3. If the applicant is denied SSI or RSDI for a reason other than lack of disability, the department of medicaid shall make its own disability determination.
If SSA makes a finding of presumptive disability based upon the available evidence which reflects a high degree of probability that the individual will meet the disability requirements, the medicaid applicant meets the disability requirements necessary to qualify for medicaid. If it is later determined that the SSA decision was erroneously made and the individual was without fault in the determination, no attempt shall be made to recover medicaid payments made on behalf of the recipient.

The CDJFS shall determine medicaid eligibility for an individual residing in a state institution. The CDJFS in the county in which the state institution is located has case responsibility except when either the temporary absence or inter-county transfer provisions, as set forth in rules 5160:1-1-50.1 and 5160:1-1-51 apply.

(1) An individual who either is under the age of twenty-two or is age sixty-five or over and who resides in a Title XIX-certified section of a state institution for the mentally ill is assumed to meet the limiting physical factor requirement of disability.

(2) An individual of any age who resides in a Title XIX-certified section of a state institution for individuals with intellectual disabilities is assumed to meet the limiting physical factor requirement of disability.

(3) An individual of any age who resides in a state institution for the mentally ill, in a section certified as a Title XIX intermediate care facility for individuals with intellectual disabilities (dual diagnosis unit), is assumed to meet the limiting physical factor requirement of disability.

Presumptive disability conditions or impairments:

(1) Amputation of a leg at the hip;
(2) Total deafness;
(3) Total blindness;
(4) Bed confinement or immobility without a wheelchair, walker, or crutches, due to a longstanding condition, excluding recent accident and recent surgery;
(5) A stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm;
(6) Cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms;
(7) Down’s syndrome;
(8) An allegation of severe mental deficiency made by a person applying on behalf of an individual who is at least seven years of age, in accordance with the definition of “mental deficiency” in paragraph (B) of this rule;
(9) A child who has not attained his or her first birthday and the birth certificate or other evidence (e.g., the hospital admission summary) shows a weight below twelve hundred grams (two pounds, ten ounces) at birth;
(10) A child who has not attained his or her first birthday and the birth certificate or other evidence (e.g., the hospital admission summary) shows a gestational age at birth on the table below with the corresponding birth-weight indicated:

<table>
<thead>
<tr>
<th>Gestational age (in weeks)</th>
<th>Weight at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>37-40</td>
<td>Less than 2000 grams (4 pounds, 6 ounces)</td>
</tr>
<tr>
<td>36</td>
<td>1875 grams or less (4 pounds, 2 ounces)</td>
</tr>
<tr>
<td>35</td>
<td>1700 grams or less (3 pounds, 12 ounces)</td>
</tr>
</tbody>
</table>
(11) Diseases and/or illnesses that are a result of human immunodeficiency virus (HIV) infection, and the diseases and/or illnesses have progressed to the point where the individual is unable to work for a minimum of twelve consecutive months, as confirmed by a licensed physician;

(12) An individual who is receiving hospice services because of terminal illness;

(13) A spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand held assistive devices for more than two weeks;

(14) End stage renal disease with ongoing dialysis; or

(15) Amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease).

Replaces: 5160:1-3-03, 5160:1-3-11

Effective: 01/22/2015

Five Year Review (FYR) Dates: 01/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/12/2015

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02

Prior Effective Dates: 9/3/77, 1/1/81, 9/6/84, 8/1/85, 8/1/86 (emer.), 10/3/86, 7/1/87 (Emer.), 8/3/87, 1/1/88 (Emer.), 3/28/88, 10/1/88 (Emer.), 12/20/88, 4/1/90, 10/1/91 (Emer.), 12/1/91, 12/2/91, 12/20/91, 1/1/92 (Emer.), 3/20/92, 12/22/92 (Emer.), 1/1/93(Emer.), 2/11/93, 3/20/93, 9/1/93, 8/1/95 (Emer.), 10/30/95, 4/1/99, 10/1/02, 11/25/02, 1/1/05
MEMTL 90

Effective Date: January 22, 2015

(A) This rule sets forth the eligibility criteria and benefits for the medicare premium assistance programs (MPAP). These programs are: qualified medicare beneficiary (QMB), specified low-income medicare beneficiary (SLMB), and qualified individuals (QI-1).

(B) Definitions.

(1) "Enrolled," for the purpose of this rule, means an individual is in receipt of benefits under a medicare health plan.

(2) "MPAP" means any or all of the medicare premium assistance programs: QMB, SLMB, and QI-1.

(3) "MPAP resource limit" means the maximum amount of resources allowed under section 1905(p)(1) of the Social Security Act (as in effect on December 1, 2013), as adjusted annually according to the change in the consumer price index for urban areas.

(4) "Qualified," for the purpose of this rule, means an individual is eligible to receive benefits under a medicare health plan, whether or not the individual has applied for those benefits.

(5) "QI-1" means the qualified individual group, for which federal funds are provided each year, described in section 1902(a)(10)(E)(iv) of the Social Security Act (as in effect on December 1, 2013). Enrollment for this group may be limited.

(6) "QMB" means the qualified medicare beneficiary group described in section 1905(p)(1) of the Social Security Act (as in effect on December 1, 2013).

(7) "SLMB" means the specified low-income medicare beneficiary group described in section 1902(a)(10)(E)(iii) of the Social Security Act (as in effect on December 1, 2013).

(C) Eligibility. To be eligible for a medicare premium assistance program, an individual must meet all of the following conditions:

(1) Be qualified for coverage under medicare part A (part A).

(a) An individual is ineligible for MPAP benefits under this rule if the individual is receiving medicare benefits as described in paragraph (C) of rule 5160:1-3-02.2 of the Administrative Code, but may be eligible for benefits under rule 5160:1-3-02.2 or 5160:1-5-03 of the Administrative Code.

(b) An individual otherwise qualified for QMB must be enrolled in either part A or medicare part B (part B) for the administrative agency to provide benefits under this rule.

(c) An individual otherwise qualified for SLMB or QI-1 must be enrolled in part A for the administrative agency to provide benefits under this rule.

(2) Have resources, as determined under Chapter 5160:1-3 of the Administrative Code, no greater than the MPAP resource limit as defined in paragraph (B)(3) of this rule for an individual or for a couple, whichever is appropriate.

(3) Have income, as determined under paragraph (D) of this rule, within the MPAP need standards as set forth in rule 5160:1-3-03.5 of the Administrative Code.

(4) For QI-1, be otherwise ineligible for medical assistance under Chapters 5160:1-1 to 5160:1-5 of the Administrative Code, except that an individual who is eligible only with a delayed spenddown, as set forth in rule 5160:1-3-04.1 of the Administrative Code, can be eligible for QI-1 benefits.

(5) Meet the application, conditions of eligibility, and verification requirements set forth in Chapter 5160:1-2 of the Administrative Code.
Countable income shall be determined under Chapter 5160:1-3 of the Administrative Code, except the annual cost of living increase (COLA) shall be deducted from the individual's income beginning in January of each year and continuing through the end of the month after the month in which the updated federal poverty guidelines are published in the Federal Register.

Coverage periods.

(1) The effective date of QMB coverage is the first day of the month after the month in which the administrative agency approves QMB benefits. No retroactive coverage is available for QMB.

(2) Eligibility for SLMB benefits begins no earlier than the third month prior to the month of application, provided the individual met all eligibility criteria including enrollment in part A during the three-month period.

(3) QI-1 eligibility is limited by calendar year.
   (a) QI-1 coverage begins on the first day of the month of application. If all eligibility requirements were met in any of the three months before the month of application, coverage begins three months before the month of application, except that retroactive coverage under QI-1 cannot begin earlier than January of the year of application.
      (i) The individual must reapply for QI-1 coverage each year.
      (ii) Federal funding is limited, and only a certain number of individuals can be covered. Applications are considered and individuals are approved for coverage on a first-come, first-served basis each year until the number of covered individuals equals that year's maximum.
   (b) QI-1 coverage ends on December thirty-first of each year because, by federal statute, authorization for the program ends on December thirty-first each year unless Congress reauthorizes it.
   (c) QI-1 coverage will end prior to December thirty-first if the individual dies or ceases to be an Ohio resident. In that case, coverage will end on the last day of the month in which either of those events occurs.

(4) The date and effect of termination of MPAP benefits is set forth in rule 5160:1-3-02.6 of the Administrative Code.

Benefits.

(1) If an individual is eligible for QMB, the administrative agency shall pay the individual's:
   (a) Premiums for part B and, if a premium is charged, part A; and
   (b) Medicare deductibles; and
   (c) Medicare co-pays; and
   (d) Medicare coinsurance costs.

(2) If an individual is eligible for SLMB or QI-1, the administrative agency shall pay the individual's part B premiums.

Administrative agency responsibilities. The administrative agency shall:

(1) Explore eligibility for medicaid and for all MPAP categories if a medicaid applicant is qualified for part A. The agency shall advise the individual:
   (a) Of the categories of medicaid or MPAP for which the individual is eligible, the individual's right to decline payment of premiums, co-pays, or coinsurance costs, and the effect of declining MPAP payments; and
   (b) That if an individual is qualified for benefits under part A or part B, whether or not a premium would be charged for those benefits, the Ohio department of medicaid (ODM) is prohibited from paying for prescriptions on behalf of that individual.
If an individual is eligible for QMB:

(a) Approve benefits under QMB and pay the part A, if applicable, and part B premiums on behalf of a QMB-eligible individual as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month after the administrative agency approves QMB coverage; and

(b) Provide form ODM 07212 "Explanation of Qualified Medicare Beneficiary (QMB) Medicaid Coverage" (rev. 7/2014) to the individual; and

(c) For individuals who are not receiving free part A, but who could receive part A benefits by paying a premium, coordinate enrollment in parts A and B with ODM and the social security administration (SSA).

If the individual is eligible for SLMB, approve benefits under SLMB and pay the individual's part B premium as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month SLMB coverage begins.

If an individual is determined to be eligible for QI-1:

(a) Approve QI-1 for eligible individuals on a first-come, first-served basis each year; and

(b) Pay the individual's part B premium as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month QI-1 coverage begins.

Determine whether coverage for any category of benefits under this rule should have been effective prior to the effective date in the electronic medicare buy-in system. If coverage should have begun earlier, the CDJFS shall request that ODM manually buy-in the individual with the correct coverage effective date.

Deny benefits under this rule if:

(a) Any of the conditions for denial set forth in rule 5160:1-2-01 of the Administrative Code are met; or

(b) The individual is eligible only for benefits under QI-1 and there is insufficient funding for the QI-1 program.

Terminate benefits under this rule if:

(a) An individual no longer meets the eligibility criteria for any covered group under this rule; or

(b) Any of the conditions for termination set forth in rule 5160:1-2-01 of the Administrative Code are met; or

(c) The individual was eligible for benefits under QI-1 but becomes eligible for another category of medicaid, including ongoing spenddown medicaid as set forth in rule 5160:1-3-04.1 of the Administrative Code.

Coordinate enrollment with the individual, the SSA, and ODM's buy-in unit.

Individual responsibilities. An individual:

(1) Who is otherwise eligible for QMB but who is not currently in receipt of part A or part B must apply at the SSA for part A or part B.

(2) Who is otherwise eligible for SLMB but who is not currently in receipt of part A must apply at the SSA for part A.

(3) Must inform the CDJFS of any actions by the SSA on the individual's application for part A or part B, or any changes in the individual's part A or part B coverage.

Replaces: 5160:1-3-01.1
Effective: 01/22/2015
Five Year Review (FYR) Dates: 01/22/2020
**MEMTL 33**

**Effective Date: October 1, 2006**

**Most Current Prior Effective Date: October 1, 2002**

(A) The purpose of this rule is to describe the eligibility requirements for individuals residing in a continuing care retirement community (CCRC), life care community, or a philanthropic long-term care facility (LTCF).

(B) Definitions.

(1) "Continuing care retirement communities" and "life care communities" mean housing communities that provide different types of care based on each resident's need over time. CCRCs and life care communities may range from independent living in an apartment to assisted living to full-time care in a nursing facility. Residents may move from one setting to another, based on their needs, but continue to live as part of the community. Generally, CCRCs require a written contract and an entrance fee, in addition to monthly fees. CCRCs and life care communities may also be philanthropic facilities.

(2) An "entrance fee" means a payment generally required for admission to a CCRC and life care community and may vary in amount based on the type of housing accommodations and/or type of care.

(3) An "individual" means an applicant for or recipient of a medical assistance program.

(4) A "philanthropic long-term care facility" means a not-for-profit long-term care facility.

(C) Philanthropic long-term care facility.

(1) An aged, blind or disabled person, living in a philanthropic long-term care facility, who has entered into a life care contract with the LTCF, is eligible for medicaid, if all medicaid eligibility requirements and the following conditions are met:

   (a) The philanthropic LTCF must provide evidence that it is financially unable to operate. The LTCF must show that the total financial situation, of the LTCF, indicates the LTCF is financially unable to fulfill its responsibilities under the life care contract (rather than showing the individual has exhausted the amount of money turned over to the long-term care facility); and

   (b) The entrance fee would be depleted had the individual paid the facility at the medicaid long-term care rate for a comparable facility.

(2) An individual residing in a philanthropic long-term care facility who has not entered into a life care contract must have eligibility for medical assistance determined in accordance with Chapter 5101:1-39 of the Administrative Code.

(D) For purposes of determining or redetermining eligibility for medical assistance on or after February 8, 2006, an individual's entrance fee for admission to a CCRC or life care community must be considered an available resource to the individual when all of the following conditions are met:

(1) The entrance fee can be used to pay for care, under the terms of the entrance contract, should other resources or income of the individual be insufficient; and

(2) The individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the contract and leaves the CCRC or life care community; and

(3) The entrance fee does not confer an ownership interest in the CCRC or life care community.

Replaces: 5101:1-39-02.2
Effective Date: October 1, 2006
R.C. 119.032 review dates:

Certification:
Promulgated Under: 111.15

Statutory Authority: 5111.01, 5111.011

Rule Amplifies: 5111.01, 5111.011

Prior Effective Dates: 9/3/77, 10/26/78, 5/1/79, 9/21/79, 2/21/80, 6/18/89, 10/1/02
MEMTL 90

Effective Date: January 22, 2015

(A) This rule sets forth the eligibility requirements, coverage period, and benefits of the qualified disabled and working individuals (QDWI) program.

(B) Definitions.

(1) "Enrolled", for the purposes of this rule, means that an individual is in receipt of benefits under a medicare health plan.

(2) "QDWI" means the qualified disabled and working individuals program established by section 1905(s) of the Social Security Act (as in effect on December 1, 2013). This program is sometimes referred to as the qualified working disabled individuals (QWDI) program.

(C) Eligibility. To receive QDWI benefits, an individual must:

(1) Be enrolled in medicare part A (part A) under section 1818A of the Social Security Act (as in effect on December 1, 2013). Coverage can be identified as being provided under section 1818A of the Social Security Act when the individual:

   (a) Has not reached age sixty-five; and
   (b) Has lost disability benefits under Title II of the Social Security Act (as in effect on December 1, 2013) solely due to earnings in excess of the substantial gainful activity (SGA) level established by the social security administration (SSA); and
   (c) Is paying a premium for part A coverage; and
   (d) Has provided no document or communication from the SSA indicating another basis for part A coverage.

(2) Have countable income, as determined under Chapter 5160:1-3 of the Administrative Code, which does not exceed two hundred per cent of the federal poverty level for the individual's family size.

(3) Have countable resources, as determined under Chapter 5160:1-3 of the Administrative Code, which do not exceed twice the standard under the supplemental security income (SSI) program.

(4) Not be otherwise eligible for medicaid.

(5) Meet the application, conditions of eligibility, and verification requirements set forth in Chapter 5160:1-2 of the Administrative Code.

(D) Coverage period.

(1) Eligibility for QDWI benefits begins no earlier than the third month prior to the month of application, provided the individual met all eligibility criteria including enrollment in part A during the three-month period.

(2) The date and effect of termination of QDWI benefits is set forth in rule 5160:1-3-02.6 of the Administrative Code.

(E) Administrative agency responsibilities. The administrative agency shall:

(1) Deny benefits under this rule if any of the conditions for denial set forth in rules 5160:1-2-01 and 5160:1-2-10 of the Administrative Code are met; or

(2) Terminate benefits under this rule if any of the conditions for termination set forth in rules 5160:1-2-01 and 5160:1-2-10 of the Administrative Code are met; or

(3) Approve benefits if an individual is eligible for QDWI benefits, and pay the individual's monthly part A premium as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month that QDWI coverage begins.
Individual responsibilities. The individual must inform the county department of job and family services (CDJFS) of any changes in the individual's part A or part B coverage.

Replaces: 5160:1-3-01.2
Effective: 01/22/2015
Five Year Review (FYR) Dates: 01/22/2020
Certification: CERTIFIED ELECTRONICALLY
Date: 01/12/2015
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
With the implementation of the SSI program in January 1974, various grandfathering provisions were enacted to assure that aged, blind, and disabled persons previously eligible for cash assistance and medicaid under the former programs of aid would not be disadvantaged by the new eligibility conditions under the SSI program.

"Cash assistance," for the purpose of this rule, means the receipt of at least one of the following: Ohio works first (OWF), supplemental security income (SSI) or residential state supplement (RSS), or the former programs of aid known as aid for dependent children (ADC), aid for the aged (AFA), aid for the blind (AFB), and aid for the disabled (AFD).

Under the grandfathering provisions, certain persons who were eligible for medicaid in December 1973 are entitled to continued medicaid eligibility coverage even though they may not meet the medicaid eligibility requirements imposed beginning in January 1974 for the coverage of the aged, blind, and disabled.

(1) The grandfathered groups are the following:

(a) An individual who is the recipient of mandatory supplement payments administered by the social security administration is automatically eligible for medicaid.

(b) Any individual who was eligible in December 1973 as a dependent spouse remains eligible as long as the dependent spouse continues to be the spouse of and lives with the former cash assistance recipient of AFA, AFB, or AFD, and if the dependent spouse's needs were considered in determining the amount of assistance payable to the recipient in December 1973. The dependent spouse must meet all other requirements for medicaid except limiting physical factor.

(c) An individual who was eligible for medicaid in December 1973 because the individual met the definition of blindness or disability in effect under the former programs of AFB or AFD remains eligible for medicaid under the following criteria:

(i) The individual meets all current requirements for medicaid eligibility except for blindness or disability; and

(ii) The individual was eligible for medicaid in December 1973 as blind or disabled, whether or not the individual received cash assistance in December 1973; and

(iii) For each consecutive month after December 1973, the individual has continued to meet the December 1973 criteria for blindness or disability; and

(iv) For each consecutive month after December 1973, the individual has continued to meet all other eligibility requirements which were in effect December 1973.

(d) Individuals eligible despite the October 1972 twenty per cent general increase in RSDI:

(i) An individual who would currently be eligible for SSI or cash assistance except for the amount of increased income resulting from the October 1972 twenty per cent general increase in RSDI is eligible for medicaid if, for the month of August 1972, the individual met the following criteria:

(a) The individual was eligible for and receiving cash assistance under the ADC, AFA, AFB, or AFD programs, and

(b) The individual received and was entitled to monthly retirement, survivors and disability insurance (RSDI) benefits.
(ii) Only the October 1972 RSDI increase is disregarded. Any subsequent increases in RSDI are not disregarded.

(iii) Although the amount of the October 1972 RSDI increase is disregarded in determining financial eligibility, the individual must meet all of the current eligibility requirements for medicaid or the ADC eligibility requirements which were in effect on July 16, 1996.

(e) An individual who was eligible for medicaid in December 1973 because the individual was an inpatient or resident of a Title XIX institution, and who would have been eligible for cash assistance if not in the institution, is entitled to continued medicaid as long as the individual continues to meet the medicaid eligibility requirements in effect in December 1973 and continues to require institutional care.

(2) Failure to meet any one of the conditions listed in paragraph (C)(1) of this rule renders the individual ineligible under the blind or disabled grandfathering provisions.

(3) A blind or disabled grandfathered individual permanently loses grandfathered status when the individual fails to meet any December 1973 eligibility requirement for any one month.

(4) Any change in circumstances requires a redetermination of eligibility based upon all the conditions set forth in paragraph (C)(1) of this rule.

Replaces: 5160:1-3-02
Effective: 01/22/2015
Five Year Review (FYR) Dates: 01/22/2020
Certification: CERTIFIED ELECTRONICALLY
Date: 01/12/2015
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 9/3/77, 10/26/78, 5/1/79, 9/21/79, 2/7/80, 10/1/98, 10/1/02
MEMTL 90

Effective Date: January 22, 2015

(A) Section 1619 of the Social Security Act (as in effect October 1, 2014) comprises two basic provisions:

(1) Section 1619(a) extends special SSI cash to individuals whose earnings preclude eligibility for regular SSI cash benefits. Individuals in 1619(a) status may still receive an SSI cash benefit in addition to the individual's earned income.

(2) Section 1619(b) extends medicaid coverage to individuals whose earnings, although high enough to preclude eligibility for regular SSI cash benefits or special SSI cash benefits under section 1619(a), may not be enough for medical care.

(B) To determine initial medicaid eligibility for sections 1619(a) and 1619(b), the administrative agency shall:

(1) Verify that the individual is currently in 1619(a) or 1619(b) status, as determined by the social security administration (SSA).

(2) Determine that the individual was eligible for medicaid the month prior to the month the individual qualified for section 1619(a) or 1619(b) per the SSA.

(a) The administrative agency must use the month immediately preceding the first month of the most recent period of eligibility under section 1619.

(b) The individual will be determined eligible for medicaid for purposes of this rule if the individual met all of the medicaid eligibility requirements for the month prior to the month of 1619 eligibility except for meeting his or her spenddown obligation that is defined in rule 5160:1-3-04.1 of the Administrative Code.

(3) When determining medicaid eligibility for an individual in 1619(a) or (b) status, or for an eligible couple when one spouse is eligible under 1619 provisions and the other spouse is not, the spenddown medicaid policy shall not apply to either spouse even though the couple's budget would result in a spenddown liability.

(4) Individuals or couples eligible for medicaid through the spenddown provision and who become eligible under the 1619 provisions will no longer be required to meet a spenddown regardless of their source(s) of income as long as they remain eligible under the 1619 provisions.

(C) Protection of medicaid benefits under 1619 status.

(1) An individual who has been determined eligible for medicaid because of 1619 status is protected from losing medicaid benefits under this provision as long as the individual remains in 1619(a) or (b) status.

(2) The individual may have income or resources in excess of the medicaid requirements and remain eligible for regular medicaid, with no spenddown liability, under the 1619 provisions.

(3) If the individual's 1619 status ends, the individual's medicaid protection is lost.

Replaces: 5160:1-3-02.3

Effective: 01/22/2015

Five Year Review (FYR) Dates: 01/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/12/2015

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02

Prior Effective Dates: 7/1/87 (Emer.), 8/3/87, 1/1/88, 4/1/89 (Emer.), 6/18/89, 9/1/93, 10/1/02
MEMTL 90

Effective Date: January 22, 2015

(A) This rule sets forth:

(1) The eligibility criteria for benefits under the medicare part B buy-in agreement between the social security administration (SSA) and the Ohio department of medicaid (ODM), which allows ODM to pay medicare part B (supplemental medical insurance) premiums for certain medicaid-eligible individuals even if those individuals are not eligible for a medicare premium assistance program (MPAP) set out in rule 5160:1-3-02.1 of the Administrative Code; and

(2) The beginning date of payment of medicare part A (part A) or medicare part B (part B) benefits under this rule; and

(3) The date and effect of termination of benefits under the medicare buy-in or an MPAP; and

(4) The process of coordinating enrollment with ODM and the SSA.

(B) Definitions.

(1) "Medicare buy-in" means the program and process of paying part A or part B benefits on behalf of an eligible individual.

(2) "Part B buy-in" means the agreement under which ODM pays part B premiums on behalf of individuals even if those individuals are not eligible for benefits under rule 5160:1-3-02.1 or 5160:1-3-02.2 of the Administrative Code.

(C) Eligibility criteria. To be eligible for payment of the part B premium under the medicare buy-in agreement, an individual must meet all three of the following requirements:

(1) Be eligible for part B.

(2) Be eligible for a category of medicaid other than:

   (a) Medicaid with a spenddown calculated under rule 5160:1-3-02.1 of the Administrative Code; or

   (b) Breast and cervical cancer project medicaid as set forth in rules 5160:1-5-02 through 5160:1-5-02.4 of the Administrative Code; or

   (c) Presumptive medicaid as set forth in rule 5160:1-1-62 of the Administrative Code.

(3) Be receiving at least one of the following:

   (a) Medicare premium assistance under rule 5160:1-3-02.1 of the Administrative Code.

   (b) One of the following kinds of cash assistance:

      (i) Ohio works first (OWF); or

      (ii) Supplemental security income (SSI); or

      (iii) Residential state supplement.

   (c) Four-month extended coverage as set forth in rule 5160:1-1-65 of the Administrative Code.

   (d) Grandfathered medicaid as set forth in rule 5160:1-3-02.3 of the Administrative Code.

   (e) Foster care maintenance payments or adoption assistance payments as set forth in rule 5160:1-1-63 of the Administrative Code.

   (f) Medicaid as a result of section 1619(b) of the Social Security Act (as in effect October 1, 2014) as set forth in rule 5160:1-3-02.4 of the Administrative Code.

   (g) Deemed OWF as described in 42 C.F.R 435.115 (as in effect October 1, 2014).
Long-term care services in a Title XIX certified nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

Home and community-based (HCB) services, including the program of all inclusive care for the elderly (PACE), under a waiver described in Agency 5160 of the Administrative Code.

Coordination of enrollment. If an individual is eligible for benefits under this rule or rule 5160:1-3-02.1 or 5160:1-3-02.2 of the Administrative Code, or would be eligible if the individual were enrolled in part A or part B, the county department of job and family services (CDJFS) shall coordinate the individual's receipt of benefits.

1. If the individual:
   a. Is or has ever been in receipt of part A or part B benefits, the CDJFS shall approve MPAP or part B buy-in benefits for the individual in the electronic eligibility system.
   b. Has never received part A or part B benefits, the CDJFS shall:
      i. Inform the individual that the Ohio department of medicaid (ODM) can not pay medicare premiums until the individual has enrolled in part A or part B through the SSA; and
      ii. Advise the individual to apply for part A or part B benefits, and advise the individual that the CDJFS will assist upon request; and
      iii. Advise the individual to report the approval of part A or part B benefits to the CDJFS immediately, so payment of premiums can be approved; and
      iv. Approve MPAP or part B buy-in benefits for the individual in the electronic eligibility system upon being informed that the individual has been enrolled by the SSA in part A or part B.

2. After three weeks, if the electronic submission was not successful, the CDJFS shall submit a completed ODM 07102 "Changes in Medicaid Health Care Coverage Date and Medicare Buy-In Eligibility" (rev. 07/2014) to the ODM buy-in unit.

Coverage period.

1. Start date.
   a. For MPAP benefits under rule 5160:1-3-02.1 of the Administrative Code or for QDWI under rule 5160:1-3-02.2 of the Administrative Code, the beginning date for payment of premiums is addressed in those rules. If an individual is eligible for MPAP benefits under rule 5160:1-3-02.1 of the Administrative Code and also eligible for part B buy-in under this rule, payment of part B premiums begins on the earlier of the coverage date under rule 5160:1-3-02.1 of the Administrative Code or the coverage date under this rule.
   b. For individuals eligible for payment of premiums under the part B buy-in agreement, eligibility begins:
      i. The first month an individual is eligible for both medicare and cash assistance as defined in paragraph (C)(3)(b) of this rule; or
      ii. The first day of the second month after the administrative agency made the determination the individual was eligible for medicaid, if the individual is not in receipt of cash assistance as defined in paragraph (C)(3)(b) of this rule.

2. Termination date. Eligibility for payment of medicare premiums under this rule, rule 5160:1-3-02.1 of the Administrative Code, or rule 5160:1-3-02.2 of the Administrative Code ends on the earliest of the following dates:
   a. The last day of the month in which the individual dies; or
   b. The last day of the last month in which the individual is entitled to part B benefits; or
(c) The last day of the last month in which the individual meets the eligibility criteria for MPAP, QDWI, or medicare part B buy-in benefits, if notice was provided to the centers for medicare and medicaid (CMS) no later than the twenty-fifth day of the second month of ineligibility; or

(d) The last day of the second month before CMS received notice the individual was no longer eligible for MPAP, QDWI, or medicare part B buy-in benefits, if notice was not provided within the time limit in paragraph (E)(2)(c) of this rule.

(F) Retroactive termination. An individual's part B premium payment under buy-in can be terminated retroactively for as many as two months before the state's notice to CMS that the individual is no longer eligible.

(1) After CMS receives notice from ODM, CMS sends the individual a notice stating the individual is responsible for paying part B premiums beginning with the month following the last month of buy-in coverage. Because of administrative delays, an individual can already be in the third month after buy-in termination and owe three months of part B premiums before receiving notice that buy-in coverage has been terminated.

(2) The individual may request equitable relief from CMS under certain conditions specified by CMS in its notice.

Replaces: 5160:1-2-03
Effective: 01/22/2015

Five Year Review (FYR) Dates: 01/22/2020
Certification: CERTIFIED ELECTRONICALLY
Date: 01/12/2015

Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 8/15/82, 10/1/02, 1/1/10
This rule describes the qualified long-term care partnership (QLTCP) program.

Definitions.

(1) "Estate recovery" means the program set forth in rule 5160:1-2-07 of the Administrative Code.

(2) "Qualified long-term care partnership" (QLTCP) means the program established under section 5164.86 of the Revised Code, under which an individual's resources are disregarded in eligibility determinations and at estate recovery in the amount of benefits paid to or on behalf of the individual by a QLTCP policy.

A QLTCP policy is one that meets all of the following requirements:

(1) On the date the policy was issued, the state in which the insured resided had in place an approved state plan amendment which provides, pursuant to 42 U.S.C. 1396p(b) (as in effect on March 1, 2014), for the disregard of resources in an amount equal to the insurance benefit payments made to or on behalf of an individual who is a beneficiary of a QLTCP policy; and

(2) The policy is a qualified long-term care insurance policy, as defined in 26 U.S.C. 7702B(b) (as in effect March 1, 2014); and

(3) The policy meets the requirements set forth by the Ohio department of insurance in section 3923.41 of the Revised Code, or, if purchased outside Ohio, meets the requirements of an approved state plan amendment, as described in paragraph (C)(1) of this rule, in the state of purchase.

At application or reapplication for long-term care services, a home and community-based services (HCBS) waiver, or the program of all inclusive care for the elderly (PACE), an individual's resources will be disregarded up to the dollar amount of benefits paid to or on behalf of the individual by a QLTCP policy.

(1) The administrative agency shall determine medicaid eligibility in accordance with the eligibility rules contained in Chapters 5160:1-1 to 5160:1-6 of the Administrative Code.

(2) An individual may apply for long term care services before exhausting the benefits of a QLTCP policy. If an individual applies for and is eligible to receive medicaid coverage before the QLTCP policy is exhausted, the QLTCP insurer must make payment for medical care to the maximum extent of their liability before medicaid funds may be used to pay providers for covered long-term care services.

(3) If an individual has applied for and been found eligible to receive medicaid, and then receives additional resources, the individual continues to be eligible for medicaid to the extent the total value of all disregarded resources does not exceed the individual's QLTCP disregard plus the applicable resource allowance.

(4) A QLTCP disregard cannot reduce patient liability or cost of care.

Improper transfers of resources, as described in rule 5160:1-3-07.2 of the Administrative Code, are treated as follows when there is a QLTCP disregard.

(1) If an individual becomes eligible for medicaid through the application of a QLTCP disregard, then makes a transfer of disregarded resources that would otherwise be considered an improper transfer, no restricted medicaid coverage period applies. The disregarded value of the transferred resource continues to be considered part of the individual's QLTCP disregard.

(2) If an individual becomes eligible for medicaid through the application of a QLTCP disregard after making a transfer that would otherwise be considered an improper transfer:
(a) If the value of the individual's remaining countable resources plus the value of the transferred resources is less than or equal to the individual's QLTCP disregard plus the applicable resource limit, no restricted medicaid coverage period applies. The disregarded value of the transferred resource is considered part of the individual's QLTCP disregard.

(b) If the value of the individual's remaining countable resources plus the value of the transferred resources is greater than the individual's QLTCP disregard plus the applicable resource limit:

(i) The individual's remaining QLTCP disregard is determined by adding the individual's original QLTCP disregard amount to the applicable resource limit, then subtracting the individual's current countable resources and any amounts that had previously been transferred without a restricted medicaid coverage period as a result of a QLTCP disregard.

(ii) The individual's remaining QLTCP disregard is subtracted from the amount that would otherwise have been considered improperly transferred. The difference is the amount improperly transferred; a restricted medicaid coverage period is calculated for the difference in accordance with rule 5160:1-3-07.2 of the Administrative Code.

Replaces: 5160:1-2-11
Effective: 12/01/2014
Five Year Review (F Y R) Dates: 12/01/2019
Certification: CERTIFIED ELECTRONICALLY
Date: 11/04/2014
Promulgated Under: 119.03
Statutory Authority: 5162.21, 5163.02, 5164.86
Rule Amplifies: 5162.21, 5164.86
Prior Effective Dates: 9/1/07
MEMTL 97

Effective Date: February 10, 2015

(A) This rule addresses the process of determining disability for medicaid eligibility purposes.

(B) Definitions.

(1) "Administrative agency," for the purpose of this rule, means the county department of job and family services (CDJFS).

(2) "Continuing disability review" is the process by which the DDA determines whether the individual continues to meet the disability criteria for medicaid eligibility. The DDA will conduct a continuing disability review, in accordance with SSA policy, for an individual who was previously approved for disability or blindness by the DDA but whose initial social security disability application is still pending.

(3) "Current medical information" means medical records that originated within eighteen months of the date of initial application or continuing disability review.

(4) "Deferred" means that the disability packet contains an incomplete or insufficient amount of current medical information for the DDA to approve, deny or continue the disability or blindness claim.

(5) "Disability begin date" means the date the individual is otherwise eligible for medicaid and meets the limiting physical factor.

(6) "Disability determination" is the process by which the DDA determines whether the individual meets the social security administration's definition of "blind" or "disabled" for medicaid eligibility. The DDA determines blindness and disability in accordance with SSA policy.

(7) "Disability packet" consists of all required forms specified in paragraph (C) of this rule and all available current medical information to support the individual's disability claim. The disability packet is submitted by the administrative agency to the disability determination area (DDA) for a disability determination.

(8) "Disability review date" means the date, determined by the DDA, that the individual's current disability approval will expire.

(9) "Limiting physical factor" is a non-financial eligibility criterion consisting of a physical or mental characteristic or impairment, or a combination of physical or mental characteristics or impairments, that may limit the individual's ability to work. An individual meets the limiting physical factor by meeting the criteria of age, blindness or disability as set forth in rule 5160:1-3-02 of the Administrative code.

(10) "SSA disability benefits" are disability benefits provided to an individual and authorized by the social security administration (SSA) under Title II and/or Title XVI of the Social Security Act (as in effect October 1, 2014).

(C) Administrative agency responsibilities. The administrative agency shall:

(1) Determine medicaid eligibility in accordance with the eligibility rules contained in Chapters 5160:1-1 through 5160:1-6 of the Administrative Code.

(2) Determine the limiting physical factor is met and shall not submit a disability packet to the DDA when the individual:

(a) Is sixty-five years of age or older; or

(b) Has been approved for SSA disability benefits for the individual's own disability or blindness; or
Has been determined to need a skilled or intermediate level of care (LOC) in accordance with chapter 5160-3 of the Administrative Code. When it is determined that the individual no longer needs a skilled or intermediate LOC, the limiting physical factor is no longer met.

(3) Determine the limiting physical factor is not met and shall submit a disability packet to the DDA for a disability determination when the individual's only potential medicaid eligibility is for a category that requires a disability determination, and the individual:

(a) Alleges or appears to have a physical or mental impairment or combination of impairments that may limit his or her ability to work;
(b) Alleges or appears to be blind; or
(c) Has an application for SSA disability benefits pending with the SSA.

(4) Determine the limiting physical factor is not met and shall submit a disability packet to the DDA for a disability determination when the individual is potentially eligible for alien emergency medical assistance (AEMA) and requires a disability determination in accordance with rule 5160:1-1-91 of the Administrative Code.

(5) Presume the limiting physical factor is met and shall also submit a disability packet to the DDA for a disability determination when:

(a) The individual or another person who is applying on behalf of the individual alleges, or the individual appears to have at least one of the specific impairments or conditions meeting the presumptive disability criteria set forth in rule 5160:1-3-02 of the Administrative Code; or
(b) The individual is determined to have a presumptive disability by the SSA and has an application for SSA disability benefits pending.

(6) Upon request, assist the individual with obtaining medical documentation to support the disability or blindness claim, including, if necessary, the use of administrative funds to assist the individual with receiving a medical, psychological or eye examination to determine whether the individual is blind or disabled.

(7) Obtain and/or assist the individual in obtaining all available current medical information that pertains to the individual's alleged impairment(s) or combination of impairments, as well as any other information requested by the DDA, and submit it in the disability packet. This includes existing medical information, tests, services or records from other entities such as the SSA, opportunities for Ohioans with disabilities, workers' compensation, etc.

(8) Provide the forms listed in this paragraph to the individual, the individual's legal representative, another person applying on behalf of the individual, or the treating physician(s).

(a) ODM 07302 "Basic Medical" (rev. 07/2014);
(b) ODM 07308 "Mental Functional Capacity Assessment" (rev. 07/2014) when the individual has or appears to have a mental impairment; and
(c) ODM 03606 "Physician Certification of Medication Dependency" (rev. 07/2014) when applicable.

(9) Complete the ODM 07004 "Social Summary Report for Disability Determination" (rev. 07/2014).

(10) Obtain signed copies of form ODM 03397 "Authorization for the Release or Use of Protected Health Information (PHI)" (rev. 07/2014) from the individual for all providers who have or may have current medical information.

(11) Complete the ODM 03605 "CDJFS Referral to DDU" (rev. 07/2014) using current medical information.

(12) Submit the disability packet to the DDA for a disability determination and for a continuing disability review.
(13) When the DDA has deferred a disability determination, and the administrative agency is unable to obtain all of the requested additional medical information, resubmit the initial disability packet and any additional information to the DDA for a final decision.

(14) Submit the following information to the DDA for the individual's continuing disability review prior to the disability review date:

(a) A new disability packet. The disability packet shall contain all required forms specified in paragraph (C) of this rule and all available current medical information to support the disability claim;

(b) The previously approved disability packet; and

(c) Any other information requested by the DDA.

(D) Individual responsibilities.

(1) When the individual alleges a disability or blindness, the individual shall assist the administrative agency with obtaining all available current medical information that supports the disability or blindness claim.

(2) As a condition of medicaid eligibility, the individual is required to:

(a) Apply for any SSA disability benefits to which the individual may be entitled; and

(b) File a timely appeal of any denial of SSA disability benefits that happens either while the initial disability determination is still being adjudicated or during the individual's disability certification period.

(E) Disability determination area (DDA) responsibilities.

(1) The DDA shall approve, deny or defer disability determinations, and shall notify the administrative agency via the electronic eligibility system.

(2) The DDA shall determine the disability begin date and continuing disability review date for approved disability claims, and shall inform the administrative agency via the electronic eligibility system.

(3) In accordance with paragraph (C)(13) of this rule, when the initial disability packet is resubmitted to the DDA because the administrative agency was unable to obtain the requested additional medical information, the DDA shall make a final decision on the case based upon the information available in the initial disability packet, and shall notify the administrative agency of the decision via the electronic eligibility system.

(F) Medicaid eligibility during initial disability determination.

(1) If the individual meets all other medicaid eligibility criteria and also meets the limiting physical factor in accordance with paragraph (C)(2) of this rule, the administrative agency shall approve medicaid eligibility, and shall not submit a disability packet to the DDA.

(2) If the individual meets all other medicaid eligibility criteria and also presumptively meets the limiting physical factor in accordance with paragraph (C)(4) of this rule, the administrative agency shall approve medicaid eligibility and shall also submit a disability packet to the DDA for a disability determination.

(3) If the individual meets all other medicaid eligibility criteria, but has not yet been determined to meet the limiting physical factor, the administrative agency shall not approve medicaid eligibility and shall submit a disability packet to the DDA for a disability determination.

(4) If the SSA denies or does not complete a disability determination due to a non-disability reason, the administrative agency shall submit a disability packet to the DDA for a disability determination.

(a) If the DDA approves the disability, the limiting physical factor is met and the administrative agency shall approve medicaid eligibility.
(b) If the DDA denies the disability, the limiting physical factor is not met and the administrative agency shall not approve medicaid eligibility.

(5) When the individual's SSA application is pending, the administrative agency shall submit a disability packet to the DDA for a disability determination.

(a) If the DDA approves the disability, the limiting physical factor is met and the administrative agency shall approve medicaid eligibility until the earlier of the date SSA makes a decision on the SSA application or the continuing disability review date.

(b) If the DDA denies the disability, the limiting physical factor is not met and the administrative agency shall deny medicaid eligibility until the SSA makes a decision on the SSA application.

(i) If the SSA approves SSA disability benefits, the limiting physical factor is met and the administrative agency shall determine medicaid eligibility based upon the initial medicaid application and continue medicaid eligibility until a medicaid redetermination is required.

(ii) If the SSA denies SSA disability benefits, the limiting physical factor is not met and the administrative agency shall deny medicaid eligibility.

(G) Medicaid eligibility during continuing disability review.

(1) If the individual continues to meet all other medicaid eligibility criteria, the administrative agency shall continue medicaid eligibility while the DDA is conducting a continuing disability review.

(2) If the SSA had previously denied or did not complete a disability determination for a non-disability reason and the DDA had approved the disability, the administrative agency shall submit a new disability packet to the DDA for a continuing disability review.

(a) If the DDA approves the disability, the limiting physical factor is met and the administrative agency shall continue medicaid eligibility.

(b) If the DDA denies the disability, the limiting physical factor is not met and the administrative agency shall terminate medicaid eligibility.

(3) When the individual's initial SSA application is pending at the time of the continuing disability review, the administrative agency shall submit a new disability packet to the DDA.

(a) If the DDA approves the disability, the limiting physical factor is met and the administrative agency shall continue medicaid eligibility until the earlier of the date the SSA makes a decision on the SSA application or the next continuing disability review date.

(b) If the DDA denies the disability, the limiting physical factor is not met and the administrative agency shall terminate medicaid eligibility.

(4) If the individual's SSA application is in an appeal at the time of the continuing disability review, the administrative agency shall continue medicaid eligibility through the SSA appeals council review process, in accordance with paragraph (I) of this rule.

(H) Reapplication for medicaid. When an individual is terminated from medicaid and reapplies:

(1) Within twelve months after the disability begin date, the limiting physical factor is met. The administrative agency shall not submit a new disability packet to the DDA. The administrative agency shall apply the existing disability review date, in accordance with paragraph (G) of this rule.

(2) Beyond twelve months of the disability begin date, the limiting physical factor is not met. The administrative agency shall submit a new disability packet to the DDA for a new disability determination, in accordance with paragraphs (C) through (F) of this rule.

(I) Medicaid eligibility when SSA denials are appealed.
When the SSA makes a decision denying SSA disability benefits, the individual has a right to appeal the SSA decision.

The SSA appeal consists of three levels of administrative review that must be requested within sixty-five days and at the proper level. The levels of administrative review are reconsideration, administrative law judge (ALJ) hearing, and appeals council review. If an individual is still dissatisfied at the conclusion of the appeals council review, he or she may request judicial review by filing an action in federal court.

If the individual appeals SSA decisions timely, the administrative agency shall continue medicaid eligibility through the date the final decision is issued by the appeals council.

If the individual does not appeal the SSA decision, medicaid eligibility shall continue through the sixty-fifth day from the date of the adverse SSA disability decision. After the sixty-fifth day, the limiting physical factor is no longer met, and medicaid eligibility under the aged, blind and disabled category shall be terminated.

If the individual fails to appeal the SSA decision timely, but is later permitted by the SSA to appeal for good cause shown, the administrative agency shall restore medicaid eligibility back to the date of medicaid termination.

Replaces: 5160:1-3-03
Effective: 02/23/2015
Five Year Review (FYR) Dates: 02/23/2020
Certification: CERTIFIED ELECTRONICALLY
Date: 02/13/2015
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 9/3/77, 1/1/81, 9/6/84, 8/1/85, 7/1/87 (Emer.), 8/3/87, 1/1/88 (Emer.), 3/28/88, 10/1/88 (Emer.), 12/20/88, 4/1/90, 10/1/91 (Emer.), 12/1/91, 12/2/91, 12/20/91, 1/1/92 (Emer.), 3/20/92, 12/22/92 (Emer.), 1/1/93 (Emer.), 2/11/93, 3/20/93, 9/1/93, 8/1/95 (Emer.), 10/30/95, 4/1/99, 10/1/02, 11/25/02, 1/1/05
MEMTL 91

Effective Date: February 1, 2015

(A) This rule defines how income is treated for the purpose of determining eligibility for medical assistance for aged, blind, or disabled individuals.

(B) Definitions:

(1) "Community spouse" means an individual who is not in a medical institution or nursing facility and has an institutionalized spouse. If both spouses request or receive services under a home and community-based services (HCBS) waiver program or program of all inclusive care for the elderly (PACE), neither spouse meets this definition.

(2) "Income" means cash, income in-kind, or something of value which is received, available, and attributable to an individual. Income may be in the form of cash, including checks and money orders for in-kind items. In-kind income is not cash, but is food, shelter, or something which can be used to get food or shelter. Income is divided into two categories: earned income and unearned income. Earned income consists of wages and net earnings from employment or self-employment. Unearned income includes all other income.

(3) "Institutionalized" describes an individual who receives long term care (LTC) services in a medical institution, a long term care facility, under a home and community based services (HCBS) waiver program, or under program of all inclusive care for the elderly (PACE) for at least thirty consecutive days.

(C) Administrative agency responsibilities.

(1) Eligibility for medical assistance is dependent in part upon the amount of income available to or received by the individual.

(2) All income must be considered in determining the need of an individual.

(3) Potential income must be explored prior to approving medical assistance. An individual who does not avail himself/herself of potential income is presumed to fail to do so in order to make himself/herself eligible for medical assistance. Such non-utilization of income constitutes ineligibility unless good cause can be shown. Such income includes but is not limited to:

(a) Retirement, survivors, disability insurance (RSDI);
(b) Prouty benefits;
(c) Railroad retirement;
(d) Veterans benefits;
(e) Other public/private retirement benefits;
(f) Supplemental security income (SSI).

(4) When an eligible individual resides with an ineligible spouse or parent(s), a portion of the ineligible spouse's or parent's income must be deemed as attributable income to an eligible individual. Attributable income is assumed to be available to an eligible individual. The deeming of income is subject to conditions and limitations. Reference rule 5160:1-3-03.9 of the Administrative Code for the medical assistance deeming of income provisions.

(D) Income is counted on a monthly basis.

(1) Gross income, prior to any deductions, exemptions or exclusions, that can be reliably anticipated is considered available in calculating countable income for a month. Thus, when an individual is receiving a pension or is regularly employed or self-employed, the expected amount of income is counted. Wages are counted as earned income in the calendar month in which they are paid even if all of the work which produced the wages are performed in a prior month. If the
time of receipt of the income is at the employee's discretion, the employee must avail himself of such wages. If the payment of wages are deferred at the employee's request, the administrative agency must determine when the wages would normally have been paid and allocate them accordingly. The administrative agency must assume the wages were payable in equal segments throughout the applicable period and determine eligibility accordingly. Self-employment earnings are to be treated in accordance with rule 5160:1-2-01.9 of the Administrative Code.

(2) Allocated income is considered available in calculating countable income for a month. Allocated income is income that is/was received and is intended to cover a period greater than one month. Income which cannot be anticipated is not included in advance of its receipt but is counted when it becomes available.

(E) Under certain circumstances, the amount of income which must be determined as available to an individual may be greater than an individual will receive or have for his own use.

(1) When an individual has been court-ordered to pay child support and/or spousal support to a former spouse, these payments must not be deducted from countable income to the individual. When the child support/spousal support is paid directly to the former spouse or child's guardian by the employer or benefit payer, the income continues to be determined available income to the medical assistance applicant/recipient.

(2) Court ordered income deductions must be considered available income to the medical assistance individual. A division of marital property in a divorce settlement is not considered a court ordered income deduction in the context of this paragraph.

(3) Deductions due to a repayment of an overpayment, loan, or other debt must be considered as available income unless the amount being withheld to reduce a previous overpayment was included when determining the amount of unearned income for a previous month in the determination of medical assistance eligibility.

(4) Garnishments and liens placed against earned or unearned income of an individual must not be deducted from countable income, regardless of the purpose for the garnishment or lien.

(F) Income exclusions in the determination of medical assistance eligibility are identified in rule 5160:1-3-03.11 of the Administrative Code. Income exclusions in the determination of patient liability are identified in rules 5160:1-3-04.3 and 5160:1-3-04.4 of the Administrative Code.

(G) Verification of income.

(1) The individual's statements of source and amount of income are subject to verification. At the time of application/reapplication, the individual and household member(s) whose income affects the individual, must be required to submit documents which verify all sources of income. If necessary, the administrative agency must obtain a signed release of information and contact other sources to verify income.

(2) An individual's report of income is subject to verification when a review is conducted by the ODM quality assurance review section.

(3) The individual has the burden of verifying the sources and amounts of income, and has the responsibility of reporting income changes to the administrative agency.

(4) When an individual claims to have no income at the time of application/reapplication, the administrative agency must review the application/reapplication for inconsistencies requiring resolution. It is the individual's responsibility to support the claim of no income. However, if verification is not available and the individual has cooperated in trying to obtain it, the administrative agency may process the case based on the individual's statement as long as there is no evidence to cast doubt on the income allegations. Reference rule 5160:1-1-50.1 of the Administrative Code for additional information on acceptable verification.

(H) When income in-kind is received, the administrative agency must determine whether in-kind support and maintenance is being received in accordance with rule 5160:1-3-03.8 of the Administrative Code.
Receipt of cash, income in-kind, or something of value in a particular month is income to the individual for that month. Any portion of the income which is retained by an individual into the next month becomes a resource.

The following items are not income. This list is not all inclusive:

1. An individual may derive non-cash benefits from personal services which are not income. A personal service performed for an individual is not income to the individual where the service is not convertible to cash.

2. Payments made on behalf of an individual under credit life or credit disability policies directly to loan companies, mortgage companies, etc., are not considered income.

3. Money an individual borrows or money received as the repayment of the principal of a bona fide loan is not considered income. Any interest received on the money loaned is unearned income. If the proceeds of the loan are retained in the month following the month of receipt, they are counted as a resource.

4. A bill paid directly to a creditor or vendor by a third party unless payment is for food or shelter.

5. The amount of a premium payment for supplementary medical insurance paid by a third party on behalf of the individual.

6. The amount of money a third party pays to a long-term care facility to supplement the medical assistance per diem in order to maintain a private room for the individual in accordance with the provisions outlined in rule 5160-3-16.3 of the Administrative Code.

7. An arrearage of child support which is payable to an individual on behalf of an adult child unless the individual retains the income and does not give it to the adult child.

Replaces: 5160:1-3-08

Effective: 01/25/2015

Five Year Review (FPR) Dates: 01/25/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/15/2015

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Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02

Prior Effective Dates: 9/3/77, 12/31/77, 3/1/79, 10/1/79, 12/7/79, 1/3/80, 12/1/84 (Emer.), 2/10/85, 8/1/85, 10/1/88 (Emer.), 12/20/88, 9/1/92, 10/1/02, 7/1/05, 10/1/06
Social security child insurance and social security disability income (SSDI) of certain individuals who were in receipt of SSI benefits and became ineligible for SSI benefits due to the receipt of, or increase in, SSDI income shall, in certain circumstances, be exempted for purposes of determining medicaid eligibility. This exemption does not apply if the individual is in a long term care facility or enrolled in a home and community-based services (HCBS) waiver.

The following groups of individuals are eligible to have their SSDI income exempted:

1. Eligible widows(ers), in accordance with 42 C.F.R. 435.137 (as in effect March 1, 2014) who meet all of the following criteria:
   a. Were entitled to a monthly social security benefit for December, 1983, and
   b. Were entitled to, and received a social security widow(er)'s disability benefit for January 1984, and
   c. On or after January 1984, were made ineligible for SSI benefits because of an increase in widow(er)'s benefits that resulted from the social security amendment which eliminated the additional reduction factor for disabled widows or widowers under age sixty, and
   d. Submitted a medicaid application or reapplication prior to October 16, 1989, in order to reinstate medicaid eligibility.

2. Individuals who have a disability, who have attained the age of eighteen, and who are receiving SSDI benefits on the basis of blindness or a disability which began before they attained the age of twenty-two, in accordance with section 1634 of the Social Security Act, and who meet all of the following criteria:
   a. On or after July 1, 1987, became entitled to social security child's insurance benefits on the basis of such disability or to an increase in the amount of the child's insurance benefits which are payable, and
   b. Were in receipt of SSI benefits in the month prior to the receipt of the SSDI benefits; and
   c. Were made ineligible for further SSI benefits solely because of the receipt of, or increase in, such child's insurance benefits.

3. Widow(er)s who were in receipt of SSI benefits, in accordance with 42 C.F.R. 435.138 (as in effect March 1, 2014), and meet all of the following criteria:
   a. Are at least age sixty, and
   b. Would continue to be eligible for SSI benefits but for receipt of SSDI benefits as a disabled widow(er), and
   c. Received an SSI payment the month before the SSDI payments began, and
   d. Are not entitled to medicare part A. The SSDI payment shall be exempted only until the individual becomes entitled to medicare part A.
   e. Submitted a medicaid application on or after July 1, 1988.
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 4/17/89 (Emer.), 6/30/89, 8/1/90 (Emer.), 10/25/90, 10/24/91 (Emer.), 1/20/92, 7/1/94, 10/1/02
MEMTL 91

Effective Date: February 1, 2015

(A) The purpose of this rule is to specify whether sheltered workshop earnings are considered earned or unearned income for medicaid eligibility determinations. If services in a sheltered workshop are performed:

(1) For rehabilitation or therapeutic purposes, and the intent of supervision and control over the individual is to rehabilitate and prepare the individual for placement in outside employment, an employer/employee relationship does not exist. The income from the services performed is considered unearned income.

(2) As an employee, an employer/employee relationship exists. The income from the services performed is considered earned income.

(B) The administrative agency must evaluate each individual's case to decide whether an employer/employee relationship exists. If deductions from gross earnings are made for federal, state, or local taxes, it shall be assumed the individual is an employee, and the remuneration is considered earned income.

(C) When an individual is not participating in a rehabilitation program designed to place him in outside employment, the administrative agency shall determine if a rehabilitation plan exists. The purpose of the plan should be to rehabilitate the individual or train the individual for employment and should have a tentative ending date. If these elements do not exist in the plan, there may be an employer/employee relationship.

(D) An individual who has completed a training program but is still in the sheltered workshop due to the unavailability for outside employment is not considered participating in a rehabilitation program. Such an individual is considered an employee, and payment for services performed is considered earned income.

Replaces: 5160:1-3-14.4

Effective: 01/25/2015

Five Year Review (FYR) Dates: 01/25/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/15/2015

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02

The purpose of this rule is to set forth the need standards used in medicaid eligibility determinations for aged, blind, or disabled individuals.

Definitions.

(1) "Need standard" means the income limit above which an individual is either ineligible for a given category of medicaid for the aged, blind or disabled, or is subject to a spenddown in accordance with rules \textbf{5160:1-3-03.4} and \textbf{5160:1-3-03.9} of the Administrative Code.

(2) "Couple need standard" is equal to the current supplemental security income (SSI) benefit rate for a couple. The updated figure is published annually by the social security administration.

(3) "Individual need standard" is a dollar amount, adjusted annually by the same percentage as the social security cost of living allowance (COLA). The updated figure is published annually in the medicaid eligibility manual via a medicaid eligibility procedure letter (MEPL).

(4) The "special income level" for institutionalized individuals is equal to three hundred per cent of the current supplemental security income (SSI) benefit payment rate for an individual.

(5) The need standards for the medicare premium assistance programs (MPAP) are as follows:

(a) The QMB need standard is one hundred per cent of the federal poverty level.

(b) The SLMB need standard is one hundred twenty per cent of the federal poverty level.

(c) The QI need standard is one hundred thirty-five per cent of the federal poverty level.

(d) The QDWI need standard is two hundred per cent of the federal poverty level.

Application of need standards.

(1) For an individual, countable income is compared to the appropriate individual need standard. An institutionalized individual, even if married, is treated as an individual.

(2) For a married couple:

(a) If both members of the married couple are categorically eligible, countable income is compared to the appropriate couple need standard.

(b) If only one member of the married couple is categorically eligible, countable income may be compared to either the individual need standard or the couple need standard, in accordance with the deeming provisions set forth in rule \textbf{5160:1-3-03.9} of the Administrative Code.
(Emer.), 4/1/90, 4/2/90 (Emer.), 6/22/90, 1/1/91 (Emer.), 4/1/91, 4/2/91 (Emer.), 6/17/91, 1/1/92 (Emer.),
3/20/92, 4/1/92 (Emer.), 6/30/92, 1/1/93 (Emer.), 3/18/93, 3/25/93, 6/11/93, 9/1/93, 3/18/94, 2/1/95, 4/01/95
(Emer.), 6/11/95, 4/1/96, 1/1/97 (Emer.), 2/9/97, 12/3/97 (Emer.), 2/1/98, 1/8/99 (Emer.), 4/1/99, 1/1/00,
6/2/01, 5/12/02
(A) The purpose of this rule is to describe the calculation and treatment of rental income and expenses for Medicaid eligibility determinations.

(B) Definitions.

(1) "Rent" means a payment which an individual receives for the use of real or personal property, such as land, housing or machinery.

(2) "Net rental income" means gross rent less the ordinary and necessary expenses paid in the same taxable year. It is treated as unearned income unless the recipient is in the business of renting properties, in which case it is treated as earned income.

(3) "Ordinary and necessary expenses" are those necessary for the production or collection of rental income. In general these expenses include interest on debts, state and local taxes on real and personal property and on motor fuel, general sales taxes and expenses of managing or maintaining property.

(C) To determine net rental income:

(1) Identify countable rental income.

(a) Rental deposits.

(i) Rental deposits are not income to the landlord while subject to return to the tenant.

(ii) Rental deposits used to pay rental expenses become income to the landlord at the point of use.

(b) Do not consider rents received in months prior to Medicaid eligibility.

(2) Calculate allowable expenses.

(a) Deductible expenses include:

(i) Interest and escrow portions of a mortgage payment (at the point the payment is made to the mortgage holder).

(ii) Real estate insurance.

(iii) Repairs (i.e., minor correction to an existing structure).

(iv) Property taxes.

(v) Lawn care.

(vi) Snow removal.

(vii) Advertising for tenants.

(b) Nondeductible expenses include:

(i) Depreciation or depletion of property.

(ii) Principal portion of a mortgage payment.

(iii) Capital expenditures (i.e., an expense for an addition or increase in the value of property which is subject to depreciation for income tax purposes).

(c) Proration to determine allowable amount of expenses.

(i) In multiple family residences, if the units in the building are of approximately equal size, prorate allowable expenses based on the number of units designated for rent compared to the total number of units. If the units are not of approximately equal size, prorate allowable expenses based on the number of rooms in the rental units.
compared to the total number of rooms in the building. The rooms do not have to be occupied.

(ii) For rooms in a single residence prorate allowable expenses based on the number of rooms designated for rent compared to the number of rooms in the house. Do not count bathrooms as rooms in the house. Basements and attics are counted only if they have been converted to living spaces (e.g., recreation rooms).

(iii) For rented land, prorate expenses based on the percentage of total acres that are for rent.

(d) Do not consider expenses paid in months prior to medicaid eligibility.

(e) Expenses are deducted when paid, not when incurred.

(3) Subtract the deductible expenses paid in a month from gross rent received in the same month.

(a) If deductible expenses exceed gross rent in a month, subtract the excess expenses from the next month's gross rent and continue doing this as necessary until the end of the tax year in which the expense is paid.

(b) If there are still excess expenses, subtract them from the gross rent received in the month prior to the month the expenses were paid and continue doing this as necessary to the beginning of the tax year involved.

(c) Do not carry excess expenses over to other tax years or use them to offset other income.

(4) If an unpredictable expense is reported at a later date (e.g., a repair) deduct it in the month paid. If the expense exceeds the rent for that month, recalculate the rest of the estimated period in accordance with paragraphs (F)(1) and (F)(2) of this rule.

(5) Absent evidence to the contrary, apportion net rental income in proportion to the percentage of ownership. If the gross rent is split between the individual and another joint owner before expenses are paid, deduct expenses paid by the individual from the individual's portion of the gross rent.

(6) Use evidence from the previous months to estimate net rental income for the next twelve months; however, deduct only predictable expenses (e.g., utilities, interest payments, taxes, etc.).

(D) Verification of income and expenses. Use documents in the individual's possession (e.g., bills, receipts, etc.) to verify the gross rent and the dates received, and expenses and the dates paid. The individual's most recent federal tax return including "Schedule E" will be helpful in identifying past expenses and estimating future rental income.

(1) If no documents are available, obtain a signed statement explaining why no documents are available and providing an allegation of the gross rent and expenses paid for the period involved.

(2) If it cannot be determined whether an expense is allowable (e.g., whether it is an incidental repair or a capital expenditure) contact with the internal revenue service can be made.

Replaces: 5160:1-3-15.1

Effective: 01/25/2015

Five Year Review (FYR) Dates: 01/25/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/15/2015

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02
The purpose of this rule is to set forth the treatment of sick pay and sick leave for Medicaid eligibility determinations.

Definitions.

(1) "Sick pay" means a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability.

(2) "Sick leave" means a paid absence from duty for personal or family medical reasons.

Treatment of sick pay.

(1) Sick pay is treated as earned income (wages) if the individual receives sick pay within six months after stopping work and the income is not attributable to the employee’s own contributions toward a sick pay plan.

(2) Sick pay is treated as unearned income if:

(a) The individual receives sick pay within six months after stopping work and the income is attributable to the employee’s own contributions toward a sick pay plan; or

(b) The individual receives sick pay more than six months after stopping work.

(3) To determine the six months’ period after stopping work, begin with the first day of non-work, include the remainder of that calendar month, and include the next six full calendar months.

Treatment of sick leave. Sick leave payments are treated as earned income. Sick leave that is donated to the individual is treated the same as if it were the individual’s own leave.

Replaces: 5160:1-3-15.2
Effective: 01/25/2015
Five Year Review (F Y R) Dates: 01/25/2020
Certification: CERTIFIED ELECTRONICALLY
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Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 9/1/94
MEMTL 91

Effective Date: February 1, 2015

(A) This rule sets forth how in-kind support and maintenance is valued for purposes of determining eligibility under the medicaid aged, blind, or disabled covered groups.

(B) Definitions.

(1) "Actual value" is the dollar amount that an individual paid for an item or service, or for his/her share of an item or service.

(2) "Current market value" is the dollar amount for which an item would sell on the local open market.

(3) "Household" is a personal place of residence in which individuals share common living quarters and function as a single economic unit.

(4) "In-kind support and maintenance" is unearned income in the form of food or shelter, or something that can be used to get food or shelter, that a person is given or receives because someone else pays for it.

(5) "Living in household of another" means that:

   (a) The individual does not live in his/her own household as defined in paragraph (B)(6) of this rule; or,

   (b) The person supplying the in-kind support and maintenance lives in the same household and is not the individual's spouse, minor child, or an ineligible person whose income is deemed to the individual.

(6) "Living in own household" means that:

   (a) The individual has ownership interest or life estate in the home; or,

   (b) The individual is liable for payment of any part of a rental charge; or,

   (c) The individual pays a pro-rated share of living expenses; or,

   (d) The individual lives in a non-institutional care situation.

(7) "Non-institutional care situation" means that:

   (a) The individual has been placed by a public or private agency under a specific program of protective placement; and,

   (b) The placement is in a private household that is licensed or otherwise approved by the state to provide protective care; and,

   (c) The placing agency retains responsibility for continuing supervision of the need for placement and of the services provided; and,

   (d) The individual, the placing agency, or some other party pays for the services provided, or has a written agreement to pay for the services provided.

(8) "Presumed maximum value" is one-third the value of the "own household" medicaid need standard, as set forth in rule 5160:1-3-03.5 of the Administrative Code, plus twenty dollars.

(9) "Public assistance household" is a household in which all individuals receive some type of public income-maintenance payments, including but not limited to Ohio works first (OWF), supplemental security income (SSI), disaster relief and emergency assistance, or state or local government assistance programs based on need.

(10) "Shelter" means room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services.
In-kind support and maintenance received by an individual is excluded if:

1. It is identified as excluded in accordance with rule 5160:1-3-03.11 of the Administrative Code; or,
2. It is received from another member of a public assistance household; or,
3. The individual receives SSI and the social security administration does not reduce the individual's SSI benefit because of in-kind support and maintenance.

In-kind support and maintenance received by an individual is valued by applying the "household of another" medicaid need standard, as set forth in rule 5160:1-3-03.5 of the Administrative Code, when:

1. The individual is a recipient of SSI benefits and receives the one-third reduction in the SSI benefit; or,
2. The individual lives for an entire month in another person's household, and receives both food and shelter for the entire month from someone living in that household. If the individual receives in-kind support and maintenance but lives in his own household, or does not live for the entire month in another person's household, or does not receive all his food and shelter from another person in that household for the entire month, or receives in-kind support and maintenance from someone outside the household, in-kind support and maintenance is valued in accordance with paragraph (E) of this rule.

In-kind support and maintenance received by an individual is valued by treating the in-kind support and maintenance as countable unearned income, using the presumed maximum value when the "household of another" medicaid need standard, described in paragraph (D) of this rule, does not apply. The individual shall be provided the opportunity to demonstrate that the presumed maximum value shall not be used, in accordance with paragraph (F) of this rule.

In-kind support and maintenance received by an individual is valued by treating the in-kind support and maintenance as countable unearned income, using the current market value or actual value, whichever is less, when the individual demonstrates that:

1. The current market value of any in-kind support and maintenance received, minus any payment the individual makes for them, is less than the presumed maximum value; or,
2. The actual amount someone else pays for the individual's in-kind support and maintenance is less than the presumed maximum value.

The administrative agency shall, for purposes of determining medicaid eligibility, determine the value of in-kind support and maintenance received by an individual in accordance with this rule.

Replaces: 5160:1-3-17
Effective: 01/25/2015

Five Year Review (FYR) Dates: 01/25/2020
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MEMTL 91

Effective Date: February 1, 2015

(A) Introduction.

(1) When an eligible individual resides in the same household with his or her ineligible spouse, or an eligible child under age eighteen resides in the same household with his or her parent(s), a portion of the income and resources of such spouse or parent are included in determining the individual's eligibility for medicaid for the aged, blind or disabled.

(2) This provision sets forth a formula for calculating the amount of income that the ineligible spouse or parent is responsible to deem to an otherwise-eligible spouse or child. This formula is utilized instead of determining support and maintenance in accordance with rule 5160:1-3-03.8 of the Administrative Code.

(B) Definitions:

(1) "Allocation," for the purpose of this rule, means an amount deducted from income subject to deeming, which is considered to be set aside for the support of certain individuals other than the eligible individual.

(2) "Child," for deeming purposes, means an individual under age eighteen who lives in a household with one or both parents and is neither married nor head of household. The deeming of parental income applies through the month in which the child becomes eighteen years old. An eligible or ineligible child's income and/or resources are never deemed to parent(s) or sibling(s).

(3) "Deemed income" means income attributed to another person whether or not the income is actually available to the person to whom it is deemed.

(4) "Deemor" means an individual whose income and/or resources are subject to deeming. Such individuals include ineligible parents, sponsors of aliens, ineligible spouses, and essential persons. It does not matter whether these individuals have sufficient income or resources to deem; they are still considered to be deemors. The type of income such an individual receives does not exclude him or her from this definition.

(5) "Eligible child" means a child in the household who has applied for medicaid for the aged, blind or disabled, and who meets all of the applicable non-financial and financial medicaid eligibility criteria.

(6) "Eligible parent" means a parent in the household who has applied for medicaid for the aged, blind or disabled, and who meets all of the applicable non-financial and financial medicaid eligibility criteria.

(7) "Eligible spouse" means the member of the married couple who has applied for medicaid for the aged, blind or disabled, and who meets all of the applicable non-financial and financial medicaid eligibility criteria.

(8) "Essential person" has the same meaning as in 20 C.F.R. 416.222 (as in effect on March 1, 2014).

(9) "Household" means the eligible individual, the individual's spouse, any of the couple's children or the children of either member of the couple, the eligible child, the eligible child's parent(s), other children of the parent(s), and/or the eligible individual and the individual's essential person.

(a) A household does not exist if an individual or a group of individuals does not have a residence. In such a case, only the eligible individual's income is used to determine medicaid eligibility.

(b) If a child is born in an institution (e.g., a hospital) the child is a member of the household at the time of birth unless the parents have completed the required paperwork to give the
child up for adoption or the child has been placed in the temporary custody of a public
children's services agency.

(c) An eligible individual or an ineligible spouse or parent who is temporarily absent, as
defined in rule 5160:1-1-50.1 of the Administrative Code, is still considered to be a
member of the household for deeming purposes.

(10) "Individual," for the purpose of this rule, means a person subject to the spenddown provisions

(11) "Ineligible child" means a child in the household who does not meet all of the eligibility criteria
for medicaid for the aged, blind or disabled.

(12) "Ineligible parent" means an eligible child's parent who does not meet all of the eligibility criteria
for medicaid for the aged, blind or disabled.

(13) "Ineligible spouse" means an eligible individual's husband or wife who does not meet all of the
eligibility criteria for medicaid for the aged, blind or disabled.

(14) "Parent" means a natural or adoptive father or mother living in the same household as the
eligible child. The income of a stepparent who lives with the eligible child is deemed to the child
only when the natural or adoptive parent also lives in the household with the stepparent and the
child. If the natural or adoptive parent divorces a stepparent and the child is living with the
stepparent, the stepparent is not a parent or spouse for deeming purposes.

(15) "Sponsor" means an individual who signs an affidavit of support agreeing to support an alien as
a condition of the alien's admission for permanent residence in the U.S. An alien may have
more than one sponsor. For deeming purposes, a sponsor does not include an organization
such as the congregation of a church or a service club, or an employer who only guarantees
employment for an alien upon entry but does not sign an affidavit of support.

(16) "Sponsored alien," for purposes of this rule, means an alien whose sponsor as described in
paragraph (B)(15) of this rule is the ineligible spouse or parent in the household being
considered.

(17) "Spouse" means a person who is legally married to another under Ohio law.

(C) In accordance with 20 C.F.R. 416.1161 (as in effect on March 1, 2014), when determining the income
of an ineligible spouse, parent or sponsor of an alien, or of an ineligible child in the household, the
following items shall not be considered income:

(1) Income excluded by federal laws other than the Social Security Act;

(2) Any public income-maintenance (PIM) payments, as defined in 20 C.F.R. 416.1142(a) (as in
effect on March 1, 2014), received by the ineligible spouse or parent(s), or by an ineligible child
in the household, and any income which was counted or excluded in figuring the amount of that
payment;

(3) Any of the income of the ineligible spouse or parent that is used to determine the amount of a
PIM payment to someone else;

(4) Any portion of a grant, scholarship, fellowship, or gift used or set aside to pay tuition, fees or
other necessary educational expenses;

(5) Money received for providing foster care to an ineligible child;

(6) The value of food assistance and the value of foods donated by the department of agriculture;

(7) Food raised and consumed by members of the household;

(8) Tax refunds on income, real property, or food purchased by the family;

(9) Income used to fulfill an approved plan for achieving self-support (PASS), as defined in 20
C.F.R. 416.1181 (as in effect on March 1, 2014);
(10) The amount of court-ordered child support payments paid by a household member for a child outside the home.

(11) The value of in-kind support and maintenance;

(12) Alaska longevity bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985, met the twenty-five-year residency requirement for receipt of such payments in effect prior to January 1, 1983, and was eligible for supplemental security income (SSI);

(13) Disaster assistance as described in 20 C.F.R. 416.1150 and 416.1151 (as in effect on March 1, 2014);

(14) Income received infrequently or irregularly, as defined in 20 C.F.R. 416.1112(c)(2) and 416.1124(c)(6) (as in effect on March 1, 2014);

(15) Blind work expenses, as defined in rule 5160:1-3-03.11 of the Administrative Code, of the ineligible spouse or parent;

(16) Income of the ineligible spouse or ineligible parent which was paid under a federal, state, or local government program to provide the eligible individual with chore, attendant or homemaker services;

(17) Certain support and maintenance assistance as described in 20 C.F.R. 416.1157(c) (as in effect on March 1, 2014);

(18) Housing assistance as provided in 20 C.F.R. 416.1124(c)(14) (as in effect on March 1, 2014);

(19) The value of a commercial transportation ticket as described in 20 C.F.R. 416.1124(c)(16) (as in effect on March 1, 2014). However, if such a ticket is converted to cash, the cash is income in the month the spouse or parent receives the cash;

(20) Refunds of federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in 20 C.F.R. 416.1112(c) (as in effect on March 1, 2014);

(21) Payments from a fund established by a state to aid victims of crime, as described in 20 C.F.R. 416.1124(c)(17) (as in effect on March 1, 2014);

(22) Relocation assistance, as described in 20 C.F.R. 416.1124(c)(18) (as in effect on March 1, 2014);

(23) Combat pay received from one of the uniformed services pursuant to 37 U.S.C. 310 (as in effect on March 1, 2014);

(24) Impairment-related work expenses, as described in 20 CFR 404.1576 (as in effect on March 1, 2014), incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under title II of the act;

(25) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces, as described in 20 C.F.R. 416.1124(c)(9) and (15) (as in effect on March 1, 2014);

(26) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than section 1613(a) of the Social Security Act, in accordance with 20 C.F.R. 416.1124(c)(22) (as in effect on March 1, 2014); and

(27) Earned income of a student as described in 20 C.F.R. 416.1112(c)(3) (as in effect on March 1, 2014).

(D) If the eligible spouse or parent(s) is/are receiving Ohio works first (OWF) or SSI payments, then the payments themselves and any of the OWF- or SSI-eligible individual's own income that was used to compute eligibility for such payments are not considered available for deeming. The income of a
spouse or parent not in receipt of OWF or SSI is considered available and must be deemed even if the income was used to determine the OWF, or SSI payment for another member of the household.

(E) When an individual is living in the same household with an ineligible spouse who has income, perform the following steps to calculate the amount of income to deem to the individual:

1. Determine the ineligible spouse's income, applying any appropriate exclusions listed in paragraph (C) of this rule;

2. Deduct the appropriate allocation for each ineligible child in the household and for each eligible alien sponsored by the ineligible spouse:
   - (a) The allocation amount is the current SSI federal benefit rate (FBR), as published annually in the Federal Register, for a couple minus the current FBR for an individual.
   - (b) The allocation for each ineligible child in the household or sponsored alien is reduced by the amount of that child's or alien's income, minus any appropriate exclusions listed in paragraph (C) of this rule.
   - (c) The ineligible child or sponsored alien allocation(s) must first be taken from the ineligible spouse's unearned income; any remaining allocation amount will be subtracted from the ineligible spouse's earned income.

3. If the ineligible spouse's remaining income after subtracting the ineligible child or sponsored alien allocation is less than or equal to the current FBR for a couple minus the current FBR for an individual:
   - (a) Do not deem any income to the individual;
   - (b) Compare the individual's own income to the current medicaid need standard for an individual.

4. If the ineligible spouse's remaining income after subtracting the ineligible child or sponsored alien allocation is greater than the current FBR for a couple minus the current FBR for an individual, treat the spouses as if they were an eligible couple:
   - (a) Combine both spouses' post-allocation earned and unearned incomes;
   - (b) Subtract the twenty-dollar general disregard from the unearned income; if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income;
   - (c) Subtract sixty-five dollars from the earned income, then subtract one-half of the remaining earned income.
   - (d) If the couple's countable income is less than or equal to the current medicaid need standard for a couple, the individual is financially eligible for medicaid.
   - (e) If the couple's countable income is greater than the current medicaid need standard for a couple, the individual is subject to spenddown provisions as defined in rule 5160:1-3-04.1 of the Administrative Code.

(F) When an eligible child or children reside(s) with an ineligible parent or parents, perform the following steps to calculate the amount of income to deem to the child(ren):

1. Determine the income of the ineligible parent(s), applying any appropriate exclusions listed in paragraph (C) of this rule;

2. Deduct the appropriate allocation for each ineligible child in the household and for each eligible alien sponsored by the ineligible parent:
   - (a) There is no allocation for an ineligible child receiving PIM payments as described in paragraph (C)(2) of this rule;
   - (b) The allocation amount is the current FBR for a couple minus the current FBR for an individual.
The allocation for each ineligible child or sponsored alien in the household is reduced by the amount of that child's or sponsored alien's income minus any appropriate exclusions listed in paragraph (C) of this rule.

The ineligible child or sponsored alien allocation(s) must first be taken from the unearned income of the ineligible parent(s); any remaining allocation amount will be subtracted from the earned income of the ineligible parent(s).

The ineligible child or sponsored alien allocation(s) must first be taken from the unearned income of the ineligible parent(s); any remaining allocation amount will be subtracted from the earned income of the ineligible parent(s).

The ineligible child or sponsored alien allocation(s) must first be taken from the unearned income of the ineligible parent(s); any remaining allocation amount will be subtracted from the earned income of the ineligible parent(s).

The ineligible child or sponsored alien allocation(s) must first be taken from the unearned income of the ineligible parent(s); any remaining allocation amount will be subtracted from the earned income of the ineligible parent(s).

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disregard from the unearned income of the ineligible parent(s); if there is less than twenty dollars of unearned income, subtract the rest of the disregard from the earned income of the ineligible parent(s).

Subtract sixty-five dollars from the earned income of the ineligible parent(s), then subtract one-half of the remaining earned income.

Subtract the twenty-dollar general disreg
(a) Do not deem any income to the eligible spouse or child(ren);
(b) Compare the eligible spouse's and children's own income to the current medicaid need standard for an individual.

(4) If the ineligible spouse/parent's remaining income after subtracting the ineligible child or sponsored alien allocation is greater than the current FBR for a couple minus the current FBR for an individual:

(a) Round down the ineligible spouse/parent's income to the nearest dollar;
(b) Divide the result by the number of eligible individuals (spouse and child(ren)) and round down to the nearest dollar;
(c) Deem the resulting quotient to each eligible individual.

(5) Any income deemed to an eligible individual from an ineligible spouse/parent is added to the eligible individual's own unearned income.

(6) Subtract the twenty-dollar general disregard from each eligible individual's unearned income; if the individual has less than twenty dollars of unearned income, subtract the rest of the disregard from the individual's earned income;

(7) Subtract sixty-five dollars from the eligible individual's earned income, then subtract one-half of the individual's remaining earned income.

(8) Compare the eligible spouse's resulting countable income to the current medicaid need standard for couples:

(a) If the eligible spouse's resulting countable income is less than or equal to the current medicaid need standard for couples, the eligible spouse is financially eligible for medicaid.
(b) If the eligible spouse's resulting countable income is greater than the current medicaid need standard for couples, the eligible spouse is subject to spenddown provisions as defined in rule 5160:1-3-04.1 of the Administrative Code.

(9) Compare each eligible child's final countable income to the current medicaid need standard for an individual:

(a) If the eligible child's resulting countable income is less than or equal to the current medicaid need standard for an individual, the eligible child is financially eligible for medicaid.
(b) If the eligible child's resulting countable income is greater than the current medicaid need standard for an individual, the eligible child is subject to spenddown provisions as defined in rule 5160:1-3-04.1 of the Administrative Code.

(H) Refer to rule 5101:1-2-35 of the Administrative Code for sponsor-to-alien deeming requirements.

Replaces: 5160:1-3-19
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Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
This rule defines how retirement and income supplementing accounts (RISAs) are treated for purposes of determining medical assistance eligibility.

Definitions.

1. "Community spouse" means an individual who is not in a medical institution or nursing facility and has an institutionalized spouse. If both spouses request or receive services under a home and community-based services (HCBS) waiver program or program of all inclusive care for the elderly (PACE), neither spouse meets this definition.

2. "Individual" means:
   a. An applicant for or recipient of medical assistance; and
   b. Includes, for the purposes of this rule, the community spouse of either an institutionalized individual or an individual who requests or receives long term care services under HCBS waiver or PACE.

3. "Institutionalized" describes an individual who receives long-term care (LTC) services in a medical institution, a long-term care facility, under an HCBS waiver program, or under PACE for at least 30 consecutive days.

4. "Retirement and income supplementing accounts (RISAs)" are plans designed to provide unearned income to supplant or supplement earned income. RISAs may include, but are not limited to such plans as: public and private pension, disability, or retirement plans; defined benefit employer pension plans, profit sharing pension plans, 403(b) pension plans, money purchase pension plans, employee stock ownership plans, individual retirement accounts (IRA); KEOGH pension plans, Roth IRAs, simplified employee pension plans (SEP-IRA), and 401k pension plans; or any other pension or retirement plans authorized under 401, 403, 408 of the Internal Revenue Code (IRC) as outlined in 26 U.S.C. (as in effect on March 1, 2014), or any other enacted IRC provisions providing for a pension or retirement plan or any other similar financial vehicles administered by an individual, employer, or union. A RISA converted into an annuity shall be considered in accordance with rule 5160:1-3-05.3 of the Administrative Code.

RISAs treated as a resource.

1. A RISA is a countable resource if the individual or the community spouse has an ownership interest in the RISA and the legal ability to convert it to cash. This determination shall be made by reference to documentation describing the RISA and/or a letter from the plan administrator. Self-defined retirement plans such as an IRA or KEOGH plan are examples of this type of RISA.

2. If there is a financial penalty imposed by the plan administrator in order to convert the account to cash, the amount of the countable resource is the net amount payable to the individual after deducting the penalty. The amount payable may not be further reduced by the amount of any tax incurred by the individual as a result of the conversion of the account to cash.

3. A RISA is not a resource if an individual must terminate employment in order to obtain any lump sum or payment.

4. If the RISA is determined to be a non-countable resource, then the RISA shall be evaluated as a potential source of unearned income.

5. A RISA determined to be a resource in accordance with paragraph (C) of this rule, which is owned by an ineligible spouse or parent of a non-institutionalized individual who is otherwise eligible for Medicaid, shall not be considered available to the non-institutionalized individual.

RISAs treated as income.
The RISA shall be evaluated as a potential source of unearned income only after it is determined to be a non-countable resource.

A RISA in which an individual has the legal ability to receive regular guaranteed lifetime payments will be treated as a source of unearned income rather than as a resource. A defined benefit employer pension plan is an example of this type of RISA.

The individual is required to obtain the maximum available amount of payment from the plan. If the maximum available amount of payment requires the individual's spouse to consent to a waiver of the spouse's survivor benefits, the individual must document a good faith attempt to obtain that consent, and whether consent was obtained or refused. If consent is not obtained, the individual must elect the minimum spousal survivor benefit required by the plan.

If allowed in the plan, the individual may elect a lesser payment in favor of retaining a minimum survivor benefit for a child who can be documented to be blind or disabled, as defined in rule 5160:1-3-02 of the Administrative Code.

Administrative agency responsibilities.

1. The administrative agency must evaluate any RISA of which the individual is a beneficiary.
2. The administrative agency shall obtain the summary plan description or other document describing the rights and benefits under the RISA. A letter from the plan administrator may also be obtained to make the determinations required under this rule.
3. The administrative agency must assist with obtaining verification in accordance with rule 5160:1-1-51 of the Administrative Code.

Individual responsibilities.

1. An individual is required to provide all available documentation to aid the administrative agency in evaluating any RISA of which the individual is a beneficiary.
2. As a condition of medical assistance eligibility, the administrative agency shall require applicants and recipients to take all necessary steps to obtain any pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so. Pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, old age, survivors, and disability insurance (OASDI) benefits, railroad retirement benefits, and unemployment compensation. An individual must access potential income prior to approval of medical assistance, in accordance with rule 5160:1-3-03.1 of the Administrative Code.

Hearing rights.

1. The administrative agency must issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

Replaces: 5160:1-3-22.7
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Prior Effective Dates: 1/1/93, 7/1/94, 12/1/04, 10/1/06
Effective Date: February 1, 2015

(A) When determining medicaid eligibility for the aged, blind, or disabled, certain types of income, including income from certain sources, are not counted. This rule sets forth the types of income that are to be excluded, and the order in which they must be excluded from the individual's income.

(B) Definitions.

(1) "Blind work expense" means the portion of the individual's earned income used to meet any expenses reasonably attributable to the earning of the income if the individual is blind and under age sixty-five.

(2) "Countable income" means the total income in cash or in kind minus the income exclusions set forth in this rule. It is compared to the appropriate need standard in determining medicaid eligibility.

(3) "Exclusion" means an amount of income which does not count in determining Medicaid eligibility.

(C) Order of exclusions. Unearned income exclusions must be applied before applying earned income exclusions, and the specific order of exclusions described in paragraphs (D) and (E) of this rule must be followed.

(D) Unearned income exclusions.

(1) Unearned income excluded by federal laws other than the Social Security Act. The exclusions listed in this paragraph must be applied before applying the exclusions in paragraph (D)(2) of this rule:

(a) Supplemental security income (SSI);

(b) Income paid by public or private agencies or community groups which is either designed by law to be disregarded or given for a special purpose for medical or social services that are not food, shelter, or clothing, in accordance with 20 C.F.R. 416.1103 (as in effect on March 1, 2014);

(c) Agent orange settlement payments;

(d) Child care assistance under the Child Care and Development Block Grant Act of 1990, in accordance with 20 CFR 416, appendix to subpart K, section V (as in effect on March 1, 2014);

(e) The first two thousand dollars per calendar year received as compensation for participation in clinical trials that meet the criteria detailed in section 1612(b) of the Social Security Act (as in effect March 1, 2014);

(f) Payments made for supporting services or reimbursement of out-of-pocket expenses to volunteers participating in corporation for national and community service (CNCS, formerly ACTION) programs, in accordance with 20 CFR 416, appendix to subpart K, section V (as in effect on March 1, 2014):

(i) Americorps vista;

(ii) Special and demonstration volunteer program;

(iii) University year for ACTION (UYA);

(iv) Retired senior volunteer program (RSVP);

(v) Foster grandparents program;

(vi) Senior companion program;
(g) Energy employees occupational illness program, in accordance with 20 CFR 416, appendix to subpart K, section V (as in effect on March 1, 2014);
(h) Federal food and nutrition programs, in accordance with 20 CFR 416, appendix to subpart K, section I (as in effect on March 1, 2014):
   (i) Food assistance (formerly known as food stamps);
   (ii) The value of surplus commodities donated by the U.S. department of agriculture;
   (iii) School breakfast, lunch, and milk programs;
   (iv) Women, infants, and children program (WIC);
   (v) Nutrition programs for older Americans;
(i) Federal housing assistance provided by either:
   (i) The office of housing and urban development (HUD); or
   (ii) The U.S. department of agriculture’s rural housing service (RHS), formerly known as the farmers home administration (FHA);
(j) Filipino veterans equity compensation fund payment, in accordance with section 1002 of the American Recovery and Reinvestment Act of 2009;
(k) Student financial assistance received under the Higher Education Act of 1965 or Bureau of Indian Affairs is excluded from income and resources, regardless of use:
   (i) Pell grants;
   (ii) Academic Achievement Incentive Scholarships;
   (iii) Byrd scholars;
   (iv) Federal supplemental education opportunity grants;
   (v) Federal educational loans (federal PLUS loans, Perkins loans, Stafford loans, Ford loans, etc.);
   (vi) Gear up (gaining early awareness and readiness for undergraduate programs);
   (vii) State educational assistance programs funded by the leveraging educational assistance program;
   (viii) Work-study programs;
(l) Home energy assistance provided on the basis of need, in accordance with 20 C.F.R. 416.1157 (as in effect on March 1, 2014);
(m) Matching funds that are deposited into individual development accounts (IDAs), either demonstration project or TANF-funded, in accordance with 42 U.S.C. 604 (as in effect on March 1, 2014);
(n) Japanese-American and Aleutian restitution payments, in accordance with 50 App. U.S.C. 1989 (as in effect on March 1, 2014);
(o) Payments to victims of Nazi persecution, in accordance with 20 CFR 416, appendix to subpart K, section V (as in effect on March 1, 2014);
(p) Netherlands WUV payments to victims of persecution from 1940-1945;
(q) Department of Defense payments to certain persons captured and interned in North Vietnam, in accordance with the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 1998;
(r) Radiation exposure compensation trust fund payments, in accordance with the Radiation Exposure Compensation Act of 1990;
(s) Payments to veterans’ children with certain birth defects;
Austrian social insurance payments received under the provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506. These payments must be documented and identifiable from countable insurance;

Funds deposited into, or accrued interest on, escrow accounts established and credited as the direct result of the assistance group's involvement in the family self-sufficiency program in accordance with 24 C.F.R. 984.103 (as in effect on March 1, 2014);

VA aid and attendance and household allowances, in accordance with 20 CFR 416.1103 (as in effect on March 1, 2014). When the individual who receives an allowance pays someone else to provide services, that payment is income to the person providing the services unless that individual is a person from whom income is deemed to the original recipient of the allowance.

Payments, made to members of American Indian tribes and groups, that are excluded under the supplemental security income (SSI) program, as listed in 20 C.F.R. 416, appendix to subpart K, section IV (as in effect on March 1, 2014);

Unearned income excluded by the Social Security Act, in accordance with 20 C.F.R. 416.1124 (as in effect on March 1, 2014) unless otherwise noted. The exclusions listed in this paragraph must be applied after the exclusions listed in paragraph (D)(1) of this rule, and in the following order:

Any public agency's refund of taxes on real property or food;

Payments, including supplemental, retroactive, or auxiliary benefit payments, of assistance based on need that is wholly funded by a State or political subdivision. Disability financial assistance (DFA) and residential state supplement (RSS) payments are included in this category.

Income tax refunds, in accordance with 20 C.F.R. 416.1103 (as in effect on March 1, 2014);

Grants, scholarships, fellowships, or gifts used for paying educational expenses are either excluded or countable, depending upon their use:

Any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other necessary educational expenses at any educational institution, including vocational or technical education, is excluded from income.

Any portion of such educational assistance that is not used to pay current tuition, fees or other necessary educational expenses but is set aside to be used for paying this type of educational expense at a future date is excluded from income in the month of receipt. If these funds are not spent after nine months, they become a countable resource as of the tenth month following receipt.

Any portion of a grant, scholarship, fellowship, or gift that is not used or set aside for paying tuition, fees, or other necessary educational expenses is income in the month received and a resource the month after the month of receipt, if retained.

Food which an individual or his/her spouse raises if it is consumed by the household;

Assistance received under the Disaster Relief and Energy Assistance Act and assistance provided under any Federal statute because of a presidentially-declared disaster;

The first twenty dollars of infrequent or irregular unearned income received in a month;

Alaska longevity bonus payments;

Foster care payments;

Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of that burial fund;
Support and maintenance assistance based on need:

(i) Provided in kind by a private nonprofit agency; or
(ii) Provided in cash or in kind by a supplier of home heating oil or gas, or by a private or municipal utility company.

One-third of child support payments made by an absent parent;

Twenty dollar general income exclusion;

Unearned income used to fulfill an approved plan to achieve self-support (PASS);

Any interest on excluded burial space purchase agreement if left to accumulate as part of the value of the agreement;

The value of any commercial transportation ticket which is received as a gift and is not converted to cash;

Payments from a state compensation fund for victims of crime;

Relocation assistance;

Hostile fire pay received from the uniformed services;

Interest on a dedicated account in a financial institution, the sole purpose of which is to receive and maintain past-due supplemental security income (SSI) benefits which are required or allowed to be paid into such an account, and the use of which is restricted by section 1631(a)(2)(F) of the Social Security Act (as in effect on March 1, 2014);

Gifts to children with life-threatening conditions, within the following limitations:

(i) Gifts not converted to cash;
(ii) The first two thousand dollars of any cash gifts within a calendar year;

Interest and dividend income from a resource, whether it is exempt or countable.

AmeriCorps State and National and AmeriCorps National Civilian Community Corps cash or in-kind payments to AmeriCorps participants or on AmeriCorps participants’ behalf. These include, but are not limited to: food, shelter and clothing allowances;

Gifts to children with life-threatening conditions, within the following limitations:

State annuities for certain veterans;

Earned income exclusions. The exclusions listed in this paragraph must be applied after the unearned income exclusions, and in the following order:

1. Earned income tax credit payments and child tax credit payments;
2. The first ten dollars of infrequent or irregular earned income received in a month;
3. Student earned income exclusion (SEIE) is applied as follows:
   (a) Earned income of blind or disabled student children under the age of twenty-two, up to the SEIE monthly limit, and not more than the SEIE yearly limit. The SEIE monthly and yearly limits are updated and published annually in the medicaid eligibility policy letter that lists standards and limits that are changed by the social security administration's cost of living allowance (COLA).
   (b) Available to a student attending full-time school, college, university or a course of vocational or technical training designed to prepare students for gainful employment. The statement of the school official as to whether the child is a full-time student is acceptable verification.
4. Wages paid by the Census Bureau for temporary employment related to census activities.
5. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month;
The first sixty-five dollars of earned income in a month. This exclusion is applied to gross earnings except in cases of self-employment, where it is applied to net income.

Earned income of disabled individuals used to pay impairment-related work expenses (IRWEs), as described in 20 C.F.R. 404.1576 (as in effect on March 1, 2014);

One-half of remaining earned income in a month;

Earned income of disabled individuals used to pay impairment-related work expenses (IRWEs), as described in 20 C.F.R. 404.1576 (as in effect on March 1, 2014);

One-half of remaining earned income in a month;

Blind work expenses, as defined in paragraph (B) of this rule;

Any earned income used to fulfill an approved plan to achieve self-support (PASS);

Earned income contributed to individual development accounts (IDAs), either demonstration project or TANF-funded;

Exclusions never reduce earned or unearned income below zero.

Unused portions of a monthly exclusion cannot be carried over for use in subsequent months.

Unused earned income exclusions are never applied to unearned income.

Other than the twenty-dollar general income exclusion, no unused unearned income exclusion may be applied to earned income.

The twenty-dollar general and sixty-five-dollar earned income exclusions are applied only once to an eligible couple, even when both members have income, since the couple's earned income is combined in determining medicaid eligibility.

Replaces: 5160:1-3-18

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MEMTL 98
Effective Date: April 1, 2015

(A) The purpose of this rule is to set forth the spenddown process used in medicaid eligibility determinations for aged, blind, or disabled (ABD) individuals. The spenddown process provides a means through which an individual who meets all eligibility criteria other than the income test can qualify for coverage for one or more months as an aged, blind, or disabled individual as described in rule 5160:1-3-02.

(B) Definitions.

(1) "Aged, blind or disabled (ABD) medicaid program" means the program set forth in Chapter 5160:1-3 of the Administrative Code. The only three medicaid categories for which the spenddown process applies are: medicaid for the aged, medicaid for the blind, and medicaid for the disabled.

(2) "Countable income" has the same meaning as in rule 5160:1-3-03.11 of the Administrative Code.

(3) "Current incurred medical expense" means a medical bill or a portion of a medical bill that:

   (a) Must be:

      (i) For a medically necessary medical item or service provided to the individual or to the individual's family member during the month for which the individual is seeking to obtain medicaid eligibility through the spenddown process; and

      (ii) An expense the individual or family member is liable to pay, regardless of whether the individual or family member has already paid it.

   (b) Includes a transportation expense, as defined in paragraph (B)(13) of this rule, incurred by the individual or family member during the month for which the individual is seeking to obtain medicaid eligibility through the spenddown process.

   (c) Does not include:

      (i) An expense that has already been used in the spenddown process as a basis for approving medicaid eligibility for any individual; or

      (ii) Any expense excluded from earned income as an "impairment-related work expense (IRWE)" as described in 20 C.F.R. 404.1576 (as in effect on March 1, 2014); or

      (iii) Any expense excluded from earned income as a "blind work expense" as defined in rule 5160:1-3-03.11 of the Administrative Code; or

      (iv) An expense the individual or family member has not yet incurred for a medical item or service because it has not yet been provided.

(4) "Family member," for the purpose of this rule:

   (a) For an individual of any age, means:

      (i) The individual's spouse or deceased spouse, unless a court has eliminated the individual's duty of medical support to such spouse; or

      (ii) The individual's natural or adopted child under the age of eighteen, including a deceased child, unless a court has eliminated the individual's duty of medical support to such child; or

      (iii) The individual's former spouse, including a deceased former spouse, provided the individual has a duty of medical support to the former spouse.
For an individual under age eighteen, means:

(i) The individual's natural or adoptive parent, unless a court has eliminated such parent's duty of medical support to the individual; or

(ii) The individual's sibling (including half-siblings) under the age of eighteen, who lives with the individual; or

(iii) The individual's deceased parent, provided that the surviving parent, who lives with the individual, had a duty of medical support of the deceased parent at the time of his or her death; or

(iv) The individual's deceased sibling (including half-siblings), provided the deceased sibling lived with the individual at the time of his or her death, and a parent who lives with the individual had a duty of medical support to the deceased sibling at the time of his or her death.

Does not include a step-parent, a step-child or a step-sibling.

"Incurred" means that the individual or family member has become liable to pay a medical bill as defined in paragraph (B)(8) of this rule. An expense is incurred on the date liability for the expense arises.

"Individual," for the purpose of this rule, means a person or married couple applying for or receiving medical assistance and subject to the spenddown process in this rule.

"Medicaid need standard" means the income limit set forth in rule 5160:1-3-03.5 of the Administrative Code that is applicable to the individual.

"Medical bill" means an invoice for a medically necessary medical item or service provided to the individual or family member.

"Medical insurance premiums" means the amount paid for insurance coverage for medical items or services such as health, dental, vision, long term care, hospital, prescriptions, etc.

"Medically necessary" has the same meaning as in rule 5160-1-01 of the Administrative Code.

Medical insurance premiums as defined in paragraph (B)(9) of this rule, and nursing facility (NF) and intermediate care facility for individuals with intellectual disabilities (ICF-IID) costs of care as described in paragraph (E)(3) of this rule, are always considered medically necessary.

The administrative agency may generally accept that medical expenses and bills submitted in the spenddown process are for items or services that were medically necessary. In an unusual situation, the administrative agency may question whether an item or service was medically necessary. In such a situation, the administrative agency will need to determine whether the item or service was medically necessary by following these steps:

(i) Contact the individual and assist the individual with gathering relevant information from the medical provider and other appropriate persons about the medical necessity of the item or service.

(ii) If the medical provider of the item or service indicates that item or service was not medically necessary, the administrative agency shall not use the expense for that item or service in the spenddown process.

(iii) If the medical provider of the item or service indicates that the item or service was medically necessary, the administrative agency may use the expense for that item or service in the spenddown process in accordance with the other provisions of this rule. If the administrative agency questions the provider's statement regarding medical necessity, the administrative agency must ask the prior authorization unit (PAU) of the Ohio department of medicaid (ODM) to determine whether the item or service was medically necessary.
If the PAU decides that the item or service was medically necessary, the administrative agency must use the expense for that item or service in the spenddown process in accordance with the other provisions of this rule. The PAU decision is for the sole purpose of determining whether the item or service was medically necessary. The PAU decision is not for the purpose of determining whether to prior authorize the item or service under rule 5160-1-31 of the Administrative Code, nor for the purpose of determining whether the item or service is payable by the medicaid program.

If the PAU decides that the item or service was not medically necessary, the administrative agency shall not use the expense for that item or service in the spenddown process.

(11) "Spenddown amount" means the dollar amount by which the individual's countable income exceeds the applicable medicaid need standard. The individual must satisfy the spenddown amount in accordance with paragraph (D) of this rule in order to become eligible for medicaid for all or part of a given month.

(12) "Subject to the spenddown process" means that the individual:
   (a) Meets the criteria for age, blindness, or disability as defined in rule 5160:1-3-02 of the Administrative Code; and
   (b) Has countable monthly income that exceeds the medicaid need standard applicable to the individual; and
   (c) Is otherwise eligible for the ABD medicaid program.

(13) "Transportation expense" means a reasonable expense incurred by the individual or family member for transportation that is needed to obtain a medically necessary item or service.
   (a) Transportation expenses include but are not limited to the following:
      (i) Charges for public transportation;
      (ii) Expenses related to the transportation such as parking fees and tolls;
      (iii) The state mileage reimbursement rate as set by the Ohio office of budget and management for the use of a private motor vehicle owned by the individual or family member, in effect on the date of travel;
      (iv) The actual expense incurred by the individual or family member for transportation by a private motor vehicle not owned by the individual or family member;
      (v) Overnight lodging expenses if overnight travel is needed to obtain the medical item or service;
      (vi) Actual expenses for meals, up to thirty dollars per person per day, subject to the restrictions in paragraph (B)(13)(a)(vii) of this rule, when overnight travel is required;
      (vii) Attendant care costs and/or the costs of a companion if a medical provider verifies that an attendant and/or companion is required due to the age, physical, and/or mental condition of the individual or family member; and
      (viii) Expenses related to delivering a medical service or item to the individual or family member.
   (b) Transportation expenses do not include the following:
      (i) The cost of transportation provided to the individual or family member through county-administered transportation assistance; or
      (ii) Any transportation expenses excluded from income as an "impairment-related work expense" (IRWE) as described in 20 C.F.R. 404.1576 (as in effect on September 1, 2014); or
(iii) Any transportation expense excluded from earned income as a "blind work expense" as defined in rule 5160:1-3-03.11 of the Administrative Code.

(c) The administrative agency may generally accept that transportation expenses submitted in the spenddown process are for transportation that was needed to obtain a medically necessary item or service and that the cost is reasonable. If the administrative agency questions whether a transportation expense was needed and/or reasonable, the administrative agency will need to determine whether the expense was needed and/or reasonable by following these steps:

(i) Contact the individual and assist the individual with gathering relevant information from the medical provider and other appropriate persons concerning all of the relevant circumstances including the following:

(A) The age, physical and mental condition and transportation needs of the individual; and

(B) The medical item or service for which the individual needed the transportation; and

(C) The suitability of the transportation alternatives reasonably available to the individual; and

(D) The reasonableness of the expense based on the circumstances; and

(E) Any other relevant factors.

(ii) After considering all of the above factors, if the administrative agency determines that the expense or a portion of the expense was not needed and/or not reasonable, the administrative agency shall not use the expense in the spenddown process.

(14) "Unpaid past medical expense" (UPME) means a medical bill or a portion of a medical bill, as defined in paragraph (B)(8) of this rule, that:

(a) Is still owed, and is not subject to payment by a third party who is legally obligated to pay the bill; and

(b) Is not a NF or ICF-IID bill that is owed for services provided to a family member; and

(c) Has not been used in a previous month to meet a spenddown amount.

(C) Calculation of spenddown amount. If the individual's countable monthly income, as determined in accordance with rule 5160:1-3-03.11 of the Administrative Code, exceeds the applicable medicaid need standard, the administrative agency must calculate the amount, if any, of the monthly spenddown as follows.

(1) Medical insurance premiums.

(a) Determine the total amount of all monthly medical insurance premiums of the individual and family members. Do not round down. Subtract that amount from the individual's countable monthly income and round down to the nearest whole dollar.

(i) If the result is less than or equal to the applicable medicaid need standard, the individual is eligible for medicaid for the entire month without any monthly spenddown amount.

(ii) If the result is greater than the applicable medicaid need standard, continue to paragraph (C)(2) of this rule.

(b) An individual who is eligible for a medicare premium assistance program (MPAP) in accordance with rule 5160:1-3-02.1 of the Administrative Code has the option to decline such eligibility.

(i) If the individual accepts MPAP eligibility and the administrative agency has obtained verification that the medicaid program has begun paying the individual's
medicare premiums, then the individual's medicare premiums are not deducted in the spenddown process.

(ii) If the individual declines MPAP eligibility, then the individual's medicare premiums, if paid, are deducted at the step set forth in paragraph (C)(1)(a) of this rule.

(2) Determine the total NF or ICF-IID cost of care for the individual as calculated in accordance with paragraph (E)(3) of this rule. Do not round down. Subtract that amount from the result calculated in paragraph (C)(1)(a) of this rule and round down to the nearest whole dollar.

(a) If the result is less than or equal to the applicable medicaid need standard, the individual is eligible for medicaid for the entire month without any monthly spenddown amount.

(b) If the result is greater than the applicable medicaid need standard, continue to paragraph (C)(3) of this rule.

(3) Determine the total amount of the individual's and family members' UPMEs as determined in accordance with paragraph (E)(2) of this rule. Do not round down. Subtract that amount from the result calculated in paragraph (C)(2) of this rule and round down to the nearest whole dollar.

(a) If the result is less than or equal to the applicable medicaid need standard, the individual is eligible for medicaid for the entire month without any monthly spenddown amount.

(b) If the result is greater than the applicable medicaid need standard, the amount that is over the need standard is the individual's monthly spenddown amount. In order to become eligible for medicaid for all or part of the month, the individual must satisfy the monthly spenddown amount through one of the methods set forth in paragraph (D) of this rule.

(D) Ways of meeting spenddown. If the individual has a monthly spenddown amount calculated in accordance with paragraph (C) of this rule, the individual may satisfy, or meet, the spenddown through one or more of the following methods, and must do so each month in order to be eligible for medicaid:

(1) Recurring.

(a) The individual meets the spenddown requirement for one or more months if the individual is found eligible for Medicaid pursuant to paragraphs (C)(1), (C)(2), or (C)(3) of this rule.

(b) If the individual's and/or family members' expenses described in paragraph (C) of this rule are not equal to or greater than the spenddown amount for a given month, the individual may satisfy the spenddown amount by using one or more of the methods set forth in paragraphs (D)(2) to (D)(4) of this rule.

(2) Incurred. This method is frequently called "delayed spenddown".

(a) At the individual's option, the individual may satisfy spenddown for a month by incurring a dollar amount of current medical expenses, as defined in paragraph (B)(3) of this rule, equal to or greater than the spenddown amount for the month.

(b) If the individual does so, the individual is eligible for medicaid for the month starting on the date the individual and/or family member(s) incurred the current medical expenses that, combined with all other current incurred medical expenses for the month, equal or exceed the individual's spenddown amount for the month.

(3) Pay-in.

(a) At the individual's option, the individual may satisfy spenddown for a month by paying to the administrative agency the dollar amount of the spenddown amount for the month.

(b) If the individual does so, the individual is eligible for medicaid for the entire month.

(c) A third party may pay in on behalf of the individual or a group of individuals subject to spenddown by making payments directly to the administrative agency from the third party's funds or other funds. Such payments are not considered income, are not included
in the individual's countable monthly income, and do not negatively affect the individual's medicaid eligibility.

(4) Combination of methods.

(a) At the individual's option, the individual may meet the spenddown by using the incurred method described in paragraph (D)(2) of this rule for one or more months, and the pay-in method described in paragraph (D)(3) of this rule for one or more other months.

(b) At the administrative agency's option, the administrative agency may permit the individual to combine the two methods in a single month as follows:

(i) After the individual and/or family member has incurred an amount of current medical expenses for the month that is less than the individual's spenddown amount for the month, the administrative agency may permit the individual to pay in the difference between the current incurred medical expenses and the spenddown amount.

(ii) If the individual does so, the individual is eligible for medicaid for the month starting on the date the individual or family member incurred the last current medical expense for the month.

(5) Failure to satisfy spenddown for a month. If the individual does not satisfy spenddown for a month, the individual is not eligible for medicaid for the month but may be eligible for any future month in which the individual satisfies spenddown.

(E) Treatment of expenses.

(1) Treatment of current incurred medical expenses subject to payment by a third party:

(a) If covered by medicare:

(i) If the medicare expense is one for which the individual does not have supplemental medicare coverage, the amount of the current incurred medical expense shall be:

(A) Until the individual's medicare deductible is met: one hundred per cent of each such medicare expense; and

(B) After the individual's medicare deductible is met:

(i) If the medicare approved rate is known, twenty per cent of the medicare approved rate; or

(ii) If the medicare approved rate is not known, twenty percent of the charge for each such expense.

(ii) If the medicare expense is one for which the individual has supplemental medicare insurance, the expense shall not be considered a current incurred medical expense.

(b) If written off by the provider: the expense is treated as a current incurred medical expense for the month in which the item or service was provided.

(c) If paid, or subject to payment, by a third party that is not legally obligated to pay the expense for the individual or family member: the expense is treated as a current incurred medical expense for the month in which the item or service was provided, even if it is paid by the third party later in the same or a subsequent month.

(d) If paid or subject to payment by a third party that is legally obligated to pay the expense or a portion of the expense for the individual or family member: the expense is not treated as a current incurred medical expense.

(e) If an agency or program provides a direct medical service based on a "sliding" or "ability-to-pay" fee scale, only the amount the individual or family member is liable to pay for the service is treated as a current incurred medical expense.
Treatment of UPMEs. For the purposes of calculating the spenddown amount, the amount of UPME to be subtracted is determined in accordance with this paragraph.

(a) A UPME is considered to have been incurred in the month during which the provider supplied the item or service to the individual or family member.

(b) The individual is not required to pay or provide evidence of paying the UPME for medicaid purposes.

(c) UPMEs that may be applied in the spenddown process are:

(i) Incurred during a month in which the individual or family member receiving the item or service was not eligible for medicaid.

(ii) Incurred during a month in which the individual did not satisfy the monthly spenddown amount even with the application of the bill.

(iii) For a medical item or service that was not paid, or payable, by medicaid regardless of whether the individual receiving the item or service was eligible for medicaid during the month in which the UPME was incurred because the UPME is for an item or service:

   (A) That was not covered by medicaid; or

   (B) That was supplied by a provider who was not participating in medicaid; or

   (C) That was supplied by a medicaid provider who did not accept medicaid for the UPME.

(d) For an individual residing in a NF or ICF-IID:

(i) Any unpaid NF or ICF-IID costs incurred while the individual was in a period of restricted coverage as the result of an improper transfer of assets, as provided in rule 5160:1-3-07.2 of the Administrative Code, cannot be used as a UPME until the period of restricted coverage has expired.

(ii) Any NF or ICF-IID costs that were used to satisfy spenddown liability during a period of restricted coverage, and that remain unpaid after the period of restricted coverage has expired, shall not be used as a UPME.

(e) The administrative agency shall assist the individual with choosing the amount of the UPME to apply, and the month(s) for which to apply it. To assist the individual with making an informed decision, the administrative agency shall determine the minimum number of months for which the UPME might be applied. To make this determination, the administrative agency shall:

(i) Determine the combined total of all the UPMEs of the individual and family members;

(ii) Divide the total UPME by the result calculated in paragraph (C)(2) of this rule;

(iii) The quotient is the minimum number of months the UPME would allow the individual to meet the spenddown amount, assuming no changes in any factor that would affect the calculation of the spenddown amount.

(f) The amount of the UPME the administrative agency must subtract in the calculation of the spenddown amount in paragraph (C)(3) of this rule is either:

(i) The amount of the UPME the individual chooses to use; or

(ii) If the individual does not choose an amount to use, the difference between the result calculated in paragraph (C)(2) of this rule and the medicaid need standard applicable to the individual.
A UPME or portion of a UPME that the administrative agency applies toward the spenddown for a given month cannot be used again in the spenddown process for a future month.

A UPME or portion of a UPME that the administrative agency does not apply toward the spenddown can be used to meet the spenddown for a future month.

Treatment of NF or ICF-IID cost of care. For the purposes of calculating the spenddown amount for an individual who resides in a licensed NF or ICF-IID, the cost of care is determined as follows.

If the facility is certified for the medicaid program, the cost of care is the medicaid per diem rate.

If the facility is not certified for the medicaid program, the cost of care is the amount the facility requires the individual to pay (private pay rate) for the care received, but both of the following conditions must be met:

(i) The facility has a current license from the Ohio department of health; and

(ii) The individual's attending physician has provided a written statement that care in the facility is medically necessary.

The NF or ICF-IID cost of care of the individual's family member cannot be used in the spenddown process.

Treatment of medical expenses used in the spenddown process. Any medical expenses of the individual or family member that are used in the spenddown process to approve the individual's medicaid for a given month remain the obligation of the individual or family member and are not payable by the medicaid program.

Spenddown during retroactive months in which the individual incurred a medically necessary medical expense:

The administrative agency must determine whether the individual is retroactively eligible, including eligibility through the spenddown process, in accordance with rule 5160:1-1-51 of the Administrative Code.

If the individual is not retroactively eligible (even through the spenddown process), the individual may apply the medical expense as a UPME in the spenddown process for a month in which the individual is otherwise eligible.

If the individual is retroactively eligible (whether through the spenddown process or not):

(a) The individual may apply the UPME in the spenddown process for the retro month only if the UPME is not payable by medicaid, as described in paragraph (E)(2)(c)(iii) of this rule; and

(b) The individual must apply the UPME to meet the spenddown for the retro month(s) first, before using it to meet the spenddown for any subsequent month.

Treatment of individuals eligible for medicaid under Section 1619 of the Social Security Act.

An SSI recipient who is eligible for medicaid under Section 1619 of the Social Security Act is not subject to the spenddown process. The 1619-eligible person shall not have a spenddown amount regardless of the amount of his or her countable monthly income.

When a 1619-eligible person lives with a spouse, neither the 1619-eligible person nor his or her spouse is subject to the spenddown process. The 1619-eligible person and his or her spouse shall not have a spenddown amount regardless of the amount of their countable monthly income.

Application of proper need standard. The correct medicaid need standard applicable to the individual, as set forth in rule 5160:1-3-03.5 of the Administrative Code, is determined as follows.
(1) If a household contains a husband and wife, both of whom are subject to the spenddown process, the husband and wife are budgeted together, meaning that their countable income is compared to the couple need standard.

(2) If a household contains a husband and wife, only one of whom is subject to the spenddown process, the income of the spouse who is subject to the spenddown process may be compared to either the individual or couple need standard, in accordance with the deeming of income provisions set forth in rule 5160:1-3-03.9 of the Administrative Code.

(3) Except for married couples, each individual in a household who is subject to the spenddown process is budgeted as an individual, meaning that the individual's countable income is compared to the individual need standard.

(4) There may be more than one individual subject to the spenddown process in a household.

(I) Administrative agency responsibilities. The administrative agency shall:

(1) Determine whether the individual is eligible for medicaid under any other medicaid category, and allow the individual the choice of which category of medicaid to accept.

(2) In order to assist the individual with making informed decisions about the spenddown process, explain to and/or discuss with the individual the following:
   (a) The individual's choice to decline MPAP eligibility, as described in paragraph (C)(1)(b) of this rule;
   (b) The individual's choice of which category of medicaid to accept, as described in paragraph (I)(1) of this rule;
   (c) The various recurring and incurred spenddown medical expenses the individual may use in the spenddown process; and
   (d) The methods for satisfying spenddown.

(3) Issue the medicaid card for the month within two business days after the individual submits verification showing that current incurred medical expenses for the month satisfy the spenddown amount for the month.

(4) Implement and make available in writing reasonable policies and procedures for administering the pay-in spenddown method. The policies and procedures must:
   (a) Permit and provide reasonable methods of accepting payments by third parties on behalf of individuals and groups of individuals subject to spenddown.
   (b) Ensure that, at the individual's option, the individual will receive a medicaid card for a month on or about the first day of the month by making his or her pay-in payment by a date chosen by the administrative agency near the end of the preceding month.
      (i) If the administrative agency receives the individual's pay-in payment before the preceding month's cutoff date for benefit issuance, the administrative agency will authorize the issuance of the medicaid card in the electronic eligibility system within two business days after the cutoff date; or
      (ii) If the administrative agency receives the individual's pay-in payment on or after the preceding month's cutoff date for benefit issuance, the administrative agency will issue the card within two business days after the administrative agency receives the individual's pay-in payment.
   (c) Ensure that, at the individual's option, the individual may pay-in for a given month at any time during the month and that the administrative agency will issue the card for the month within two business days after the administrative agency receives the individual's pay-in payment.
   (d) Establish reasonable methods for accepting and accounting for pay-in payments, including but not limited to:
(i) Accepting cash payments;
(ii) Defining conditions for accepting checks or money orders; and
(iii) Establishing provisions for refunding or crediting unused pay-in amounts.

(e) Establish provisions for refunding the individual's pay-in payment for a month in the event the individual:
   (i) Becomes eligible for medicaid for the month through means other than the spenddown process;
   (ii) Becomes ineligible for medicaid for the month despite meeting the spenddown; or
   (iii) Paid in more than the spenddown amount, whether due to the individual's error or to the administrative agency's error in calculating the spenddown amount.

(5) Document all pay-in spenddown payments in the electronic eligibility system and in the individual's case record, and issue a receipt to all individuals and third parties who make pay-in spenddown payments. The documentation and receipts must state:
   (a) The date payment was received; and
   (b) The name of the person or entity from whom the payment was received; and
   (c) The name and identifying case information of the individual for whom the payment was made; and
   (d) The month of medicaid eligibility for which the pay-in payment will be used and the effective date of medicaid for that month; and
   (e) The amount of the payment and the form in which it was paid.

(6) Document in the electronic eligibility system and in the individual's case record:
   (a) For each month's current incurred medical expenses submitted by or on behalf of the individual:
      (i) The name of the provider of the medical item or service;
      (ii) The item or service provided;
      (iii) The date the item or service was provided;
      (iv) The name of the individual or family member to whom the item or service was provided;
      (v) The amount the individual or family member paid or is liable to pay for the item or service; and
      (vi) The date the administrative agency authorized the medicaid card for the month, or the specific reason(s) the administrative agency did not authorize a medicaid card for the month.
   (b) For current incurred medical expenses that require a decision by the PAU, as described in paragraph (B)(10) of this rule:
      (i) The provider's statement;
      (ii) The PAU decision; and
      (iii) All other information related to the administrative agency's decision to use or not use a current incurred medical expense in the spenddown process.
   (c) For transportation expenses that the administrative agency has determined cannot be used in the spenddown process:
      (i) A description of which specific transportation expense(s) were not used; and
      (ii) A clear explanation of the administrative agency's determination.
(d) For UPMEs:

(i) The name of the provider;
(ii) The item or service provided;
(iii) The date item or service was provided;
(iv) The name of the individual or family member to whom the item or service was provided;
(v) The amount still owed for the item or service; and
(vi) The month(s) for which the UPME or a portion of the UPME was used in the calculation of the spenddown amount.

(7) Issue proper notice and hearing rights as set forth in division 5101:6 of the Administrative Code.

(8) Not deny ABD medicaid for an individual who is applying for medicaid and does not anticipate satisfying spenddown in the month of application or in one or more future months. Instead, the administrative agency shall cause the electronic eligibility system to give the individual the type of eligibility that will only issue a medicaid card to the individual for those months for which the individual satisfies the spenddown amount.

(9) Not propose to terminate ABD medicaid for an individual who does not satisfy spenddown for one or more months. Instead, the administrative agency shall cause the electronic eligibility system to give the individual the type of eligibility that will only issue a medicaid card to the individual for those months for which the individual satisfies the spenddown amount.

(J) Individual responsibilities.

(1) The individual must submit monthly to the administrative agency, by mail, facsimile, or in person, verification of the current incurred medical expenses the individual wishes to apply against the individual's spenddown amount for the month. Verifications may include unpaid bills, statements, invoices, paid receipts, etc.

(2) For each expense, the individual must provide the name of the provider, the item or service provided, the date the item or service was provided, the name of the individual or family member to whom the item or service was provided, and the amount the individual or family member paid or is liable to pay for the item or service.

Replaces: 5160:1-3-10
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This rule defines how the administrative agency shall compute income for purposes of determining eligibility for medicaid coverage of long term care services in a long term care facility, under a home and community-based services (HCBS) waiver program, or under the program of all-inclusive care for the elderly (PACE) using the special income level.

Definitions.

1. "Community spouse" is an individual who is not in a medical institution or nursing facility and has an institutionalized spouse. Neither of two spouses, married to each other, who both request or receive services under an HCBS waiver program or PACE is considered to meet this definition.

2. "Home and community-based services" (HCBS) has the same meaning as in rule 5160:1-1-50.1 of the Administrative Code.

3. An "HCBS waiver program" is, in accordance with section 1915 of the Social Security Act (as in effect on October 1, 2014), a medicaid program approved by the centers for medicare and medicaid services (CMS) that waives certain statutory requirements otherwise needed for medicaid coverage of services.

4. "Institutionalized" describes an individual who receives long term care services in a medical institution, a long term care facility, under an HCBS waiver program, or under PACE for at least thirty consecutive days.

5. A "long term care facility" (LTCF) is a medicaid-certified nursing facility, skilled nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF-IID) as defined in chapter 5160-3 of the Administrative Code.

6. "Long term care services" are medicaid-funded, institutional or community-based, medical, health, psycho-social, habilitative, rehabilitative, and/or personal care services, as defined in chapter 5160-3 of the Administrative Code, that may be provided to medicaid-eligible individuals.

7. "PACE state administering agency" is the state agency that has signatory authority on the PACE program agreement between CMS and the PACE organization.

8. "Program of all-inclusive care for the elderly" (PACE) is a medicaid program approved by CMS for certain elderly individuals, as set forth in 42 CFR 460 (as in effect on October 1, 2014).

9. "Special income level" has the same meaning as in rule 5160:1-3-03.5 of the Administrative Code.

The administrative agency shall:

1. Determine medical assistance eligibility in accordance with Chapters 5160:1-1 to 5160:1-5 of the Administrative Code, including the individual's eligibility for low-income medicare assistance programs and medicaid buy-in, in accordance with rules 5160:1-3-02.1 and 5160:1-3-02.6 of the Administrative Code.

2. Determine if the individual meets the income criterion for medicaid eligibility for coverage of long term care services in a long term care facility, under an HCBS waiver program, or under PACE, using the special income level by utilizing the following procedure:
   a. Total all gross income, earned and unearned, of the individual, in accordance with Chapter 5160:1-3 of the Administrative Code; then,
   b. Compare the individual's gross income, earned and unearned, to the special income level.
(i) The individual meets the income criterion for medicaid eligibility using the special income level if the individual's gross income is less than or equal to the special income level. If the individual meets this income criterion, the administrative agency shall determine the individual's patient liability in accordance with rule 5160:1-3-04.3 of the Administrative Code.

(ii) The individual does not meet the income criterion for medicaid eligibility using the special income level if the individual's gross income is greater than the special income level. If the individual's gross income is greater than the special income level, the administrative agency shall compute the individual's countable income, applying applicable exclusions in accordance with rules 5160:1-3-03.11 and 5160:1-3-05.14 of the Administrative Code, and subtracting the individual's medical insurance premiums, remedial/recurring medical expenses, unpaid past medical expenses and medicaid cost of care in accordance with rule 5160:1-3-04.1 of the Administrative Code; then, compare the countable income to the appropriate medicaid need standard as described in rule 5160:1-3-03.5 of the Administrative Code.

(a) The individual meets the medicaid need standard income criterion if the countable income is less than or equal to the appropriate medicaid need standard. If the individual meets the medicaid need standard criterion, the administrative agency shall determine the individual's patient liability in accordance with rule 5160:1-3-04.3 of the Administrative Code.

(b) The individual does not meet the medicaid need standard income criterion if the countable income is greater than the medicaid need standard. If the individual does not meet the medicaid need standard criterion, the administrative agency shall determine medicaid eligibility using the spenddown provisions in accordance with rule 5160:1-3-04.1 of the Administrative Code, and the individual shall not be eligible for medicaid coverage of long term care services, including services provided in facilities, under HCBS waiver programs, and under PACE.

(3) The administrative agency shall process requests for coverage of long term care services in accordance with this rule and chapter 5160-3 of the Administrative Code.

(4) The administrative agency shall issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

(D) ODM or its designee shall determine, in accordance with this rule and chapter 5160-3 of the Administrative Code, if the individual requesting medicaid coverage of long term care services meets the level of care requirements for coverage of long term care services.

Replaces: 5160:1-3-23
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Effective Date: January 15, 2015

(A) This rule describes how resources are treated for purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Assets" include all income and resources of the individual and of the individual's spouse. This includes any income or resources the individual or the individual's spouse is entitled to, but does not receive, because of an action taken to avoid receipt of the assets by:
   
   (a) The individual or the individual's spouse; or
   
   (b) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
   
   (c) Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(2) "Countable resources" mean those resources remaining after all exclusions have been applied.

(3) An "encumbrance" means a claim, lien, charge, or liability attached to and binding on an identified piece of real or personal property.

(4) "Equity value" means the fair market value of a resource minus any encumbrance on it.

(5) "Essential person" means someone who:
   
   (a) Has continuously lived in the individual's home since December 1973; and
   
   (b) Was not eligible for state assistance in December 1973; and
   
   (c) Has never been eligible for SSI benefits as an eligible individual or as an eligible spouse; and
   
   (d) Under the state plan in effect June 1973, the state took that person's needs into account in determining the eligible individual's need for state assistance in December 1973.

(6) "Fair market value" of a resource means the going price for which real or personal property can reasonably be expected to sell on the open market in the particular geographic area involved.

(7) "Personal property" means any property that is not real property. The term includes, but is not limited to, such things as cash, jewelry, household goods, tools, life insurance policies, automobiles, promissory notes, etc.

(8) "Real property" means land and includes any buildings or immovable objects that are attached permanently to the land.

(9) "Resources" mean cash, personal property, and real property an individual and/or the individual's spouse has an ownership interest in, has the legal ability to access in order to convert to cash (if not already cash), and is not legally prohibited from using for support and maintenance.
   
   (a) An ownership interest in property, whether real or personal, is any interest recognized by law that can be protected or enforced in a court of law. Ownership interest includes either legal title or equitable interests. Access to property or a right to use property does not make that property a resource if there is no ownership interest.
   
   (b) Property cannot be a resource if the individual lacks the legal ability to access funds for spending or to convert noncash property into cash.
   
   (i) Property, or an interest in real or personal property, must have a cash value that is available to the individual upon liquidation or sale of the property.
(ii) An individual has the legal ability to access property even when action can be taken only by an agent, power of attorney, a guardian whether court appointed or not, or any other court appointed fiduciary such as a conservator of the individual. For purposes of medicaid eligibility, any action by an agent, a guardian whether court appointed or not, a power of attorney, or any other court appointed fiduciary such as a conservator is deemed to be an action by the individual. This is true even if he or she is required to petition the court to withdraw funds for the individual's care.

(c) Even with ownership interest and legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not a resource.

(10) "Resource limit" means the maximum combined value of all resources an individual can have an ownership interest in and still qualify for medicaid.

(a) For an individual, the resource limit is one thousand five hundred dollars.

(b) For a couple, whether both are eligible or one is ineligible, the resource limit is two thousand two hundred fifty dollars.

(c) A child living with a parent is considered to be an individual and has a resource limit of one thousand five hundred dollars.

(11) "Trust" is defined in rule 5160:1-3-05.2 of the Administrative Code.

(C) Treatment of non-excluded resources and determination of resource availability.

(1) The administrative agency shall evaluate and calculate the value of all resources held by an individual and the individual's spouse. An individual is ineligible for medical assistance if he or she has an ownership interest in resources with an aggregate or total countable value greater than the resource limit. The following provisions govern that process.

(a) Receipt and retention of cash or in-kind items.

(i) An individual or the individual's spouse may receive cash or in-kind items during a calendar month (the "month of receipt"). The administrative agency must treat the cash or in-kind items as a possible source of countable income for the month of receipt under the rules governing income.

(ii) If the individual or the individual's spouse retains the cash or in-kind items beyond the month of receipt, the administrative agency shall determine the availability of the cash or in-kind items as a possible countable resource under the rules governing resources.

(iii) Receipt of cash or in-kind items from the sale or exchange of timber, minerals, or other like items that are part of the land must be governed by this provision.

(b) If the individual or the individual's spouse receives cash or in-kind items as the result of an exchange, sale, replacement, or conversion of a resource, the administrative agency must consider the availability of the cash or in-kind items under the rules governing the treatment of resources, even in the first calendar month.

(2) Changes in the value of resources.

(a) The administrative agency shall review any change (increase or decrease), in the total value of an individual's resources if the change may affect the individual's eligibility for medical assistance.

(b) The review may be initiated by an eligibility worker based upon information derived from any reliable source indicating the value of an individual's available resources has increased or decreased.

(c) The administrative agency shall conduct the review of any changes as soon as possible.
(3) Discovery of previously unknown ownership interests.
   (a) Any individual alleging lack of knowledge of an ownership interest in a resource must provide a signed statement attesting to the lack of knowledge and explaining the circumstances resulting in its discovery.
   (b) The individual shall obtain supporting documentation, which may include signed statements from other individuals who are familiar with the individual's situation, that confirms the individual's claim.
   (c) If the administrative agency obtains both the signed statement and adequate supporting documentation from the individual, the administrative agency will not count an individual's ownership interest as an available resource during any period in which the individual was unaware of the ownership interest.
   (d) The administrative agency shall treat previously unknown ownership interests, including any monies (interest, dividends, or other earnings) that have accumulated on it, in the same manner as the receipt or retention of cash or in-kind items under this rule.
   (e) If either the signed statement or the supporting documentation is not provided, the administrative agency shall count an individual's ownership interest as an available resource during any period in which the individual claimed to be unaware of the ownership interest. The administrative agency shall treat the ownership interest, including any monies (interest, dividends, or other earnings) that have accumulated on it, in the same manner as the receipt or retention of cash or in-kind receipts under this rule. When appropriate, the administrative agency may refer the case to the administrative agency's benefit recovery unit.

(4) Shared ownership.
   (a) If the individual shares ownership with another person (co-owner), the resources are treated in the following manner:
      (i) If the co-owner is not the individual's spouse, parent (if the individual is under age eighteen), or child under age eighteen, and the co-owner intends to block the individual's use or disposal of the resource, the individual is required to pursue legal action to make the resource available. The individual shall provide written verification of legal action.
      (ii) If the written response indicates a legal action can make part or all of the resource available, the individual is required to pursue such a legal action.
      (iii) If the individual is unwilling to take legal action to make the resource available, the application is denied or the case is terminated for failure to cooperate.
      (iv) If the individual is unable to make the resource available because one of the owners cannot be located, the cost of a legal action is prohibitive, or the individual was unsuccessful in a legal action, the resource is not counted. Availability of the resource is reexamined at each eligibility review.
   (b) If the co-owner is the individual's spouse, parent (if the individual is under age eighteen), or child under age eighteen, the ability to use or dispose of the resource is assumed to exist unless the individual can provide documentation of the contrary.

(5) Continuing verification.
   (a) The administrative agency shall verify the value of real and personal property with each application or reapplication and any time information is provided that indicates that a change in the individual's resources may have occurred.
   (b) The administrative agency shall record the verification and place all supporting documents in the case record.

(6) Property that has not been sold.
(a) This provision governs real and personal property that has not been sold. If an individual owns property that affects eligibility and the property has not been sold, it will not be counted as an available resource as long as the individual continues to list the property for sale at an amount equal to the market value determined by the county auditor.

(b) Real property that was the principal place of residence must first be considered in accordance with rule 5160:1-3-05.15 of the Administrative Code before the provisions of this paragraph are applied.

(c) The inability to sell property may result from legal technicalities, general economic conditions in the community, or the inability to find a buyer. Before property will be determined to be excluded as a countable asset, the individual has the burden of producing reliable documentation establishing either of the following.

(i) The individual may produce documentation from two different types of knowledgeable sources in the geographic area that agree that although the property is listed for sale, the property has not been sold due to an attribute of the property or the market or both.

(A) In cases involving real property, knowledgeable sources are limited to the following: the county auditor, real estate brokers, the local office of the farmer’s home administration for rural land, the local office for the agricultural stabilization and conservation service for rural property, banks, savings and loan associations, mortgage companies and similar lending institutions, and the county extension service.

(B) In the case of personal property, knowledgeable sources are limited to the following: any professional, business owner or operator, or expert who has experience in the sale, trade, restoration, or valuation of the type of personal property in question.

(ii) Alternatively, the individual may produce documentation showing that an actual but unsuccessful sale attempt has been made.

(A) If real property, the documentation must show that the property has been, and is currently, listed for sale with a real estate agent or real estate firm in the geographic area. The property is a countable resource until it is listed for sale.

(B) The property must be listed for sale at an amount equal to the market value determined by the county auditor.

(C) The real estate agent or firm must verify that no offer to purchase has been received. The "geographic area" is the area covered by radio, television, newspaper, and other media serving the area where the individual lives and where the property is located.

(D) If the individual receives an offer for the property that is less than ninety percent of the current market value established by the county auditor, the low offer may be an indication that the value is incorrect.

(E) If it appears that the stated value is incorrect, either the individual or the administrative agency may obtain an appraisal from a second source to set a more accurate value. A second appraisal is not necessary when the purchase offer is so low that it is obviously unreasonable.

(F) The individual has the right to rebut the value by obtaining an appraisal of the property.

(7) Property that can be accessed only through legal action.

(a) If the applicant is unable to access or liquidate property due to a legal impediment or due to conduct of another person, the administrative agency shall refer the individual to legal
aid services or the prosecuting attorney's office to determine if they can assist in making the resource available. A written response to the referral is required.

(i) A failure or refusal by the prosecuting attorney or legal aid service to provide a written response shall not result in a denial for medical assistance; or

(ii) A delay in the eligibility determination by the administrative agency.

(b) If the written response indicates that a legal action can make part or all of the resource available, the individual is required to pursue such a legal action.

(c) If the individual is unwilling to take legal action to make the resource available, the application is denied or the case is terminated for a failure to cooperate.

(d) If the individual is unable to make the resource available because the cost of a legal action is prohibitive, or if the individual is unsuccessful in their legal action, the resource is not counted. Availability of the resource is reexamined at each redetermination for medical assistance.

(D) Resources of family members, households, essential persons, and aliens.

(1) The resources of spouses residing together are addressed in accordance with the deeming of resources in rule 5160:1-3-05.20 of the Administrative Code.

(2) In non-institutional settings, the administrative agency shall apply the resource limitation for an individual effective with the month following the month a couple separates or divorces or one member dies. Reference rules 5160:1-3-06.1 and 5160:1-3-06.2 of the Administrative Code for the treatment of resources for individuals receiving long term care services in a long term care facility, under a home and community-based services (HCBS) waiver program, or under the program of all-inclusive care for the elderly (PACE).

(3) The resources of a child under the age of eighteen are addressed in accordance with the deeming of resources in rule 5160:1-3-05.20 of the Administrative Code.

(4) The resources of an individual include those of his or her essential person.

(5) The resources of an alien and sponsor(s) are addressed in accordance with the sponsor-to-alien deeming requirements in Chapter 5101:1-2 of the Administrative Code.

(E) Institutionalization on or prior to December 31, 1989.

(1) An individual who entered a medical institution on or prior to December 31, 1989, and has continuously resided in the institution, is considered to have been living apart from his or her family effective the month following the month of institutionalization.

(2) All resources, in the name of the institutionalized individual, must be considered in the determination of eligibility for medical assistance.

(3) Any resource, owned solely by a spouse or parent living outside the institution, is not considered available to the spouse/child residing in the institution. Only those resources that are actually being contributed (e.g., share of savings account) shall be used in the determination of resource eligibility.

(4) The availability of a resource owned jointly.

(a) If a resource is jointly owned and listed with names connected by "and" or "or", the total amount of the resource is considered available to the institutionalized individual unless the individual provides documentation verifying the portion contributed by the other owners. Only the portion the individual contributed is considered a resource.

(b) Resources of parents are not considered available to a child who is institutionalized when the institutionalization is not temporary, even if the child returns to the home for periodic visits.

(F) Couples separated by institutionalization on or after January 1, 1990, must have resources assessed in accordance with rules 5160:1-3-06.2 to 5160:1-3-06.5 of the Administrative Code.
Couples separated by institutionalization on or prior to December 31, 1989, but the institutionalized individual returned to a community setting for thirty days or longer on or after January 1, 1990 and then is separated by another period of institutionalization, must have resources assessed in accordance with rules 5160:1-3-06.2 to 5160:1-3-06.5 of the Administrative Code. The first date of institutionalization on or after January 1, 1990 must be considered the first continuous period of institutionalization.

Resources determined excluded from the applicable resource limit for medical assistance remain excluded at the time of the individual's death. Excluded resources are part of the deceased individual's estate and are subject to the estate recovery provisions in accordance with section 5162.21 of the Revised Code.

For purposes of determining or redetermining eligibility for medical assistance on or after February 8, 2006, the entrance fee for individuals residing in a continuing care retirement community or a life care community must be considered an available resource in accordance with rule 5160:1-3-02.7 of the Administrative Code.

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MEMTL 92

Effective Date: January 15, 2015

(A) This rule defines the treatment of a trust for determining eligibility for medical assistance programs. This rule is only enforceable to the same extent as Revised Code section 5163.21

(B) Definitions.

1. "Baseline date" is defined in rule 5160:1-3-07.2 of the Administrative Code.

2. "Beneficiary" means any person benefiting in some way from the trust. The beneficiary can be the grantor or another person. There may be more than one beneficiary of a trust.

3. "Grantor" means any person who creates a trust. For purposes of this rule, the term grantor includes:
   (a) An individual;
   (b) An individual's spouse;
   (c) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, an individual or the individual's spouse; and
   (d) A person, including a court or administrative body, acting at the direction or upon the request of an individual or the individual's spouse.

4. "Irrevocable trust" means a trust that cannot be revoked by the grantor or terminated by a court. A trust terminating only upon the occurrence of an event outside the control or direction of the beneficiary or the grantor is irrevocable.

5. "Legal instrument or device similar to a trust" means any legal instrument, device, or arrangement that is not called a trust under state law, but is similar to a trust. This includes, but is not limited to, escrow accounts, investment accounts, partnerships, contracts and other similar arrangements. To constitute a legal instrument or device similar to a trust, all of the following must be present.
   (a) There must be a person holding, managing, retaining, or administering the property. For the purposes of this rule, the person holding, managing, retaining or administering the property is referred to as the trustee.
   (b) The trustee must have an equitable, legal, or fiduciary duty to hold, manage, retain, or administer the property for the benefit of another person. For the purposes of this rule, this other person is referred to as the beneficiary.
   (c) The trustee must hold identifiable property for the beneficiary.

6. "Payment" means any disbursal from the principal or income of the trust. A payment may include actual cash, non-cash or property disbursements, or the right to use and occupy real property.

7. "Payments to or for the benefit of the individual" means any payment to any person resulting in any direct or indirect benefit to the individual.

8. "Person" has the same meaning as set forth in section 1.59 of the Revised Code and includes an individual, corporation, business trust, estate, trust, partnership and association.

9. "Revocable trust" means a trust that can be revoked by the grantor or the beneficiary. For the purposes of the medicaid program, the following trusts are "revocable trusts" even if the terms of the trust state it is irrevocable:
   (a) A trust providing the trust can be terminated only by a court; or
A trust terminating upon the happening of an event, if the event can occur at the direction or control of the grantor, the beneficiary, or the trustee.

"Testamentary trust" means a trust that is established by a will. This type of trust does not take effect until after the death of the person (testator) who created the trust.

"Trust", for the purpose of this rule, means any arrangement in which a grantor transfers property (real or personal) to a trust with the intention that it be held, managed, or administered by a trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries). In this rule, the term trust includes any legal instrument or device that is similar to a trust.

"Trustee" means any person who manages a trust. A trustee manages a trust's principal and income for the benefit of the beneficiaries.

The five categories of trusts.

1. Self-settled trusts established before August 11, 1993, also referred to as medicaid qualifying trusts.

   a. A trust, or legal instrument or device similar to a trust, falls under this category if it meets all the following criteria:

      i. The trust was established before August 11, 1993;
      ii. The trust was not established by a will;
      iii. The trust was established by the individual;
      iv. The individual is or may become the beneficiary of all or part of the trust; and
      v. Payment from the trust is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

   b. The amount of the trust deemed to be an available resource to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual, assuming the full exercise of discretion by the trustee or trustees. The maximum amount includes only amounts that may be, but are not, distributed from either the income (interest) or principal of the trust.

   c. Amounts actually distributed to the beneficiary for any purpose are treated under the rules governing income.

   d. The availability of a trust in this category shall be considered whether or not:

      i. The medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medicaid, QMB, SLMB, or QI-1; and
      ii. The trustee actually exercises discretion.

   e. If any real or personal property is transferred to a medicaid qualifying trust that is not distributable to the individual, the transfer is an improper transfer subject to the rules prohibiting the improper transfer of resources.

   f. The baseline date and the regulations relating to transfers of assets are defined in rule 5160:1-3-07.2 of the Administrative Code. The following are look-back periods for transfers of assets involving trusts under this category.

      i. For revocable trusts: the distribution is an improper transfer when a portion of the trust is distributed to someone other than the individual, and the distribution is not for the benefit of the individual. The look-back period is sixty months from the baseline date. The transfer is considered to have taken place on the date upon which the payment, to someone other than the individual, was made.

      ii. For irrevocable trusts: when a portion of the trust is not distributable to the individual, it is an improper transfer. The look-back period is sixty months from the baseline date. The transfer is considered to have been made on the date the trust
was established, or, if later, the date upon which payment to the individual was foreclosed. The value of these assets is not reduced by any payments from the trust made from these unavailable assets at a later date.

(iii) For irrevocable trusts: when some or all of the trust can be disbursed to, or for the benefit of, the individual, any payment made to another person is an improper transfer. The look-back period is thirty-six months from the baseline date for improper transfers made prior to February 8, 2006. The look-back period is sixty months from the baseline date for improper transfers made on or after February 8, 2006. The transfer is considered to have been made on the date of payment to another person.

(2) Category two: self-settled trusts established on or after August 11, 1993.

(a) A trust, or legal instrument or device similar to a trust, falls under this category if it meets all of the following criteria:

(i) The trust was established on or after August 11, 1993;

(ii) The assets of the individual were used to form all or part of the corpus of the trust;

(iii) The trust was not established by a will; and

(iv) The trust was established by the individual, the spouse of the individual, a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or on behalf of the spouse of the individual, or a person, including a court or administrative body, acting at the direction or upon the request of the individual or the spouse of the individual.

(b) Revocable trusts in this category are treated as follows.

(i) The corpus of the trust is considered a resource available to the individual.

(ii) Payments from the trust to, or for the benefit of, the individual are considered unearned income.

(iii) Any other payments from the trust are considered an improper transfer subject to the rules prohibiting the improper transfer of resources.

(c) Irrevocable trusts in this category are treated as follows.

(i) If there are any circumstances under which payment from the trust could be made to, or for the benefit of, the individual, the portion from which payments could be made is considered a resource available to the individual. The administrative agency shall not take into account when payments can be made. A payment that can be made only in the future satisfies this provision.

(ii) Any payments actually made to, or for the benefit of, the individual from either the corpus or income are considered unearned income.

(iii) If a payment is made to someone other than the individual, and such payment is not for the benefit of the individual, then such payment is considered an improper transfer subject to the rules prohibiting improper transfers.

(iv) If any portion of the trust could not, under any circumstance, be made to the individual, then either the establishment of the trust, or the subsequent event that forecloses payment to the individual, is considered an improper transfer subject to the rules prohibiting the improper transfer of resources.

(v) The date of the transfer is either the date of establishment of the trust, or the date of the occurrence of the event, whichever is later.

(vi) When determining the value of the transferred resource under this provision, the value of the trust is its value on the date when payment to the individual was foreclosed.
(vii) Any income earned, or other resources added subsequent to the foreclosure date, is added to the total value of the trust.

(viii) Any payments to, or for the benefit of, the individual after the foreclosure date but prior to the application date are subtracted from the total value. Any other payments are not subtracted from the value.

(ix) Any addition of resources after the foreclosure date is considered a separate transfer.

(d) Where a trust is funded with assets of another person or persons, as well as assets of the individual, the rule provisions governing this category of trust applies only to the portion of the trust attributable to the individual.

(e) The availability of a trust in this category is considered without regard to:

(i) The purpose for which a trust is established;
(ii) Whether the trustees have or exercise any discretion under the trust;
(iii) Any restrictions on when or whether distributions may be made from the trust; and
(iv) Any restrictions on the use of distributions from the trust.

(f) The following are look-back periods for transfers of assets involving trusts under this category. The baseline date and the regulations relating to transfers of assets are defined in rule 5160:1-3-07.2 of the Administrative Code.

(i) For revocable trusts: when a portion of the trust is distributed to someone other than the individual, and the distribution is not for the benefit of the individual, the distribution is an improper transfer. The look-back period is sixty months from the baseline date. The transfer is considered to have taken place on the date upon which the payment to someone other than the individual was made.

(ii) For irrevocable trusts: when a portion of the trust is not distributable to the individual it is an improper transfer. The look-back period is sixty months from the baseline date. The transfer is considered to have been made as of the date the trust was established, or, if later, the date upon which payment to the individual was foreclosed. The value of these assets is not reduced by any payments from the trust that may be made from these unavailable assets at a later date.

(iii) For irrevocable trusts: when some or all of the trust can be disbursed to, or for the benefit of, the individual, any payment that is made to another person is an improper transfer. The look-back period is thirty-six months from the baseline date for improper transfers made prior to February 8, 2006. The look-back period is sixty months from the baseline date for improper transfers made on or after February 8, 2006. The transfer is considered to have been made as of the date of payment to another person.

(3) Category three: exempt trusts. The principal or income from any one of these trusts is exempt from being counted as a resource.

(a) Special needs trusts are not countable resources. A trust qualifies as a special needs trust if the following conditions are met.

(i) The trust contains the assets of an individual under age sixty-five. The trust may also contain the assets of other individuals.

(ii) The individual is disabled as defined in rule 5160:1-3-02 of the Administrative Code.

(iii) The trust is established for the benefit of the individual by a parent, grandparent, legal guardian, or a court.
The trust requires, upon the death of the individual, the state will receive all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual.

When such a trust was established for a disabled individual under age sixty-five, the exception for the trust continues even after the individual becomes age sixty-five, provided the individual continues to be disabled as defined in rule 5160:1-3-02 of the Administrative Code. However, with the exception of income earned by the trust, such a trust cannot be added to or otherwise augmented after the individual reaches age sixty-five. Any such addition or augmentation by the individual, with his or her own assets, after age sixty-five is treated as a transfer of assets subject to the rules prohibiting the improper transfer of resources.

Cash distributions to the individual are counted as unearned income. All other distributions from the trust are treated under the rules governing in-kind income.

Transfers of assets to a special needs trust are not subject to the improper transfer provisions in rule 5160:1-3-07.2 of the Administrative Code. However, assets held prior to the transfer to this trust are countable resources and/or income.

Qualifying income trusts (QIT) are not countable resources. A trust qualifies as a QIT only under all the following conditions and with the following limitations.

The trust is composed only of pension, social security, and other income to the individual, including accumulated interest in the trust.

(A) No resources may be used to establish or augment the trust.

(B) The income must be received by the individual, and the right to receive income cannot be assigned or transferred to the trust.

(C) If an individual has irrevocably transferred or assigned to the trust his or her right to receive income, the trust shall not meet this requirement of the rule and will not qualify as a QIT.

The trust requires that upon the death of the individual the state will receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of the individual.

Income placed in a QIT is not counted in determining the individual's eligibility for medical assistance. Thus any income (e.g., VA pension, social security benefits, private pensions, etc.) can be placed directly into a QIT, by the individual of the funds, without those funds adversely affecting the individual's eligibility for medical assistance. Income generated by the trust that remains in the trust is not income available to the individual.

All income placed in a QIT is combined with any countable income not placed in the trust to arrive at a base income figure to be used in post-eligibility calculations (i.e., patient liability or spenddown).

(A) The base income figure is used for post-eligibility deductions, including but not limited to, personal needs allowance, monthly income allowance, family allowance, and medical expenses not subject to third party payment. Any income remaining is used toward payment of the patient liability. Payments made from a QIT are not combined with the base income figure for the post-eligibility calculations.

(B) The base income figure is used when determining the spenddown budget for the individual. Any income remaining after allowable deductions permitted in rule 5160:1-3-04.1 of the Administrative Code is the individual's spenddown liability.
Pooled trusts are not countable resources. A trust qualifies as a pooled trust only under all of the following conditions.

(i) The trust contains the assets of an individual of any age who is disabled as defined in rule 5160:1-3-02 of the Administrative Code.

(ii) A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools the funds in these accounts.

(iii) Accounts in the trust are established by the individual, the individual’s parent, grandparent, or legal guardian, or a court solely for the benefit of individuals who are disabled.

(iv) To the extent that any amounts remaining in the beneficiary’s account upon the death of the beneficiary are not retained by the trust, the trust pays to the state the amount remaining in the account equal to the total amount of medical assistance paid on behalf of the beneficiary. To meet this requirement, the trust must include a provision specifically providing for such payment.

(v) Cash distributions to the individual are counted as unearned income. All other distributions from the trust are treated under the rules governing in-kind income.

(vi) Transfers of assets to a pooled trust are not subject to the improper transfer provisions in rule 5160:1-3-07.2 of the Administrative Code. However, assets held prior to the transfer to this trust are countable assets and/or income.

Supplemental services trusts are not countable resources. A trust qualifies as a supplemental services trust only if it meets the requirements of section 5815.28 of the Revised Code.

(i) Any person may establish a trust under section 5815.28 of the Revised Code only for another person who is eligible to receive services through one of the following agencies: the department of developmental disabilities; a county board of developmental disabilities; the department of mental health and addiction services.

(A) The administrative agency shall not determine eligibility for another agency’s program.

(B) An individual must provide documentation from one of these agencies establishing that the individual was determined to be eligible for services from that agency at the time of the creation of the trust.

(C) An individual may provide an order from a court of competent jurisdiction that states the individual was eligible for services from one of the agencies at the time of the creation of the trust.

(ii) At the time the trust is created, the trust principal does not exceed the maximum amount permitted. In 2006, the maximum amount permitted is two hundred twenty-two thousand dollars. The maximum amount each year thereafter is the prior year’s amount plus two thousand dollars.

(iii) The administrative agency shall review the trust to determine whether it complies with the remaining provisions of section 5815.28 of the Revised Code.

(iv) Payments from supplemental services trusts are exempt as long as the payments are for supplemental services as defined in section 5815.28 of the Revised Code. All supplemental services shall be purchased by the trustee, not through direct cash payments to the beneficiary.

If a trust is represented to be an exempt trust, but the administrative agency determines that it does not meet the requirements for one of the exempt trusts, then it is not an exempt trust and will fall under one of the four other categories of trusts.
Category four: trusts established by someone else for the benefit of the individual.

(a) A trust, or legal instrument or device similar to a trust, falls under this category if it meets the following criteria:

   (i) The trust is created by someone other than the individual;
   (ii) The trust names the individual as a beneficiary; and
   (iii) The trust is funded with assets or property that the individual never held an ownership interest in prior to the establishment of the trust.

(b) Any portion of a trust in this category is an available resource only if the trust permits the trustee to expend principal, corpus or assets of the trust for the individual's medical care, care, comfort, maintenance, health, welfare, general well-being, or a combination of these purposes. The trust is still considered an available resource even if the trust contains any of the following types of provisions:

   (i) Any provision prohibiting the trustee from making payments that would supplant or replace medicaid or public assistance, or other government assistance;
   (ii) Any provision prohibiting the trustee from making payments that would impact or affect the individual's right or ability or opportunity to receive medicaid, or public assistance, or other government assistance; or
   (iii) Any provision attempting to prevent the trust or its corpus or principal from counting as an available resource under this rule.

(c) A trust in this category normally considered as an available resource is not counted as an available resource under the following circumstances.

   (i) If the trust contains a clear statement requiring the trustee to preserve a portion of the trust for another beneficiary or remainderman, then that portion of the trust is not counted as an available resource. Terms of a trust granting discretion to preserve a portion of the trust do not qualify as a clear statement requiring the trustee to preserve a portion of the trust.
   (ii) If the trust contains a clear statement requiring the trustee to use a portion of the trust for a purpose other than the medical care, care, comfort, maintenance, welfare, or general well-being of the individual, then that portion of the trust is not counted as an available resource. Terms of a trust that grant discretion to limit the use of a portion of the trust do not qualify as a clear statement requiring the trustee to use a portion of the trust for a particular purpose.
   (iii) If the trust contains a clear statement limiting the trustee to making fixed periodic payments, then the trust is not counted as an available resource; however, the payments are treated under the rules governing income. Terms of a trust that grant discretion to limit payments do not qualify as a clear statement requiring the trustee to make fixed periodic payments.
   (iv) If the trust contains a clear statement requiring the trustee to terminate the trust if it is counted as an available resource, then it is not counted as an available resource. Terms of a trust granting discretion to terminate the trust do not qualify as a clear statement requiring the trustee to terminate the trust.
   (v) If any person obtains a judgment from a court of competent jurisdiction expressly preventing the trustee from using part or all of the trust for the medical care, care, comfort, maintenance, welfare, or general well-being of the individual, then the trust or that portion subject to the court order is not counted as a resource.
   (vi) If the trust is specifically exempt from counting as an available resource by this rule, another rule, the Revised Code, or the U.S. Code, it is not counted as a resource.
If the individual presents a final judgment from a court demonstrating that he or she was unsuccessful in a civil action against the trustee to compel payments from the trust, then it is not counted as an available resource.

If the individual presents a final judgment from a court demonstrating that in a civil action against the trustee the individual was only able to compel limited or periodic payments, then it is not counted as an available resource; however, the payments are treated under rules governing income.

If the individual provides written documentation showing the cost of a civil action brought to compel payments from the trust are cost prohibitive, then it is not counted as an available resource.

For trusts under this category, even if the trust is not counted as an available resource, any actual payments from the trust to the individual are treated under the rules governing income. Payments to any person other than the individual are not income to the individual. Payment from the trust to any person other than the individual is not an improper transfer of assets.

Category five: trusts established by will for the benefit of a surviving spouse.

A trust, or legal instrument or device similar to a trust, can be established by the will of a deceased spouse.

If there are any circumstances under which payment from the trust could be made to, or for the benefit of, the surviving spouse, the portion from which payments could be made is considered an available resource. The administrative agency shall not take into account when payments can be made. A payment that can be made only in the future satisfies this provision.

Any payments actually made to, or for the benefit of, the surviving spouse from either the corpus or income are considered unearned income.

If a payment is made to someone other than to the surviving spouse, and such payment is not for the benefit of the surviving spouse, then such payment is considered an improper transfer imputed to the surviving spouse subject to the rules prohibiting improper transfers.

If a payment is required to be made to someone other than to the surviving spouse, and such required payment is not for the benefit of the surviving spouse, then such amount is considered an improper transfer imputed to the surviving spouse subject to the rules prohibiting improper transfers.

A surviving spouse is not subject to a penalty for improper transfers under this subsection of this rule if the surviving spouse elects to take against the will.

This rule supersedes all previous rules governing trusts and the administrative agency shall apply it prospectively to all determinations and redeterminations of eligibility for all individuals. Any determination or redetermination made in accordance with this rule shall not be affected by or governed by any prior eligibility determinations made under former rules governing trusts nor shall this rule be applied retroactively to determine an individual's eligibility or liability for any prior period.

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This rule describes the treatment of annuities for the purpose of determining eligibility for medical assistance.

Definitions.

1. "Actuarially sound annuity" means a product designed to pay off the entire asset value over the actual or expected annuitant's lifetime.
2. "Annuitant" means the individual who is entitled to receive payment from an annuity.
3. "Annuited" means an annuity providing payments to the individual or other entity.
4. An "annuity" provides fixed, periodic payments, either for life or a term of years. When an individual purchases an annuity, he or she generally pays to the entity issuing the annuity a lump sum of money, in return for which he or she is promised regular payments of income for certain amounts. These payments may continue for a fixed period of time or for as long as the individual (or another designated beneficiary) lives. The annuity typically contains a remainder clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.
5. "Asset" means all income and resources of the individual and of the individual's spouse, including any income or resources that the individual or such individual's spouse is entitled to but does not receive.
6. "Balloon payment" means a lump sum equal to the initial premium minus any distribution paid out prior to the end of the annuity period.
7. "Community spouse" is defined in rule 5160:1-3-06.3 of the Administrative Code.
8. "Institutionalized" is defined in rule 5160:1-3-06.3 of the Administrative Code.
9. "Remainder beneficiary" means the individual or entity who will receive the lump sum upon the death of the annuitant or the term of the annuity has expired.
10. "Spouse" means a person who is legally married to another person under Ohio law.
11. "Transaction" means any action taken by the individual or community spouse that changes the treatment of the income or principal of the annuity.

Eligibility criteria.

1. For any annuity purchased or annuity transaction completed on or after February 8, 2006, the purchase or transaction shall be treated as the disposal of an asset for less than fair market value as outlined in rule 5160:1-3-07.2 of the Administrative Code unless:
   a. The state of Ohio is named as the remainder beneficiary in the first position for the total amount of medical assistance furnished to the individual; or
   b. The state of Ohio is named as such a beneficiary in the second position for the total amount of medical assistance furnished to the individual after the community spouse or minor or disabled child, and is named in the first position for the total amount of medical assistance furnished to the individual if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

2. The following annuity purchases are not considered a disposal of an asset for less than fair market value for any annuity purchased on or after February 8, 2006:
   a. An annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986 (as in effect on February 1, 2014); or
(b) An annuity purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of section 408 of such code, or

(ii) A simplified employee pension (within the meaning of section 408(k) of such code); or

(iii) a Roth IRA described in section 408A of such code.

(3) For any annuity purchased on or after February 8, 2006, the purchased annuity shall be irrevocable, non-assignable, and actuarially sound as determined by the life expectancy tables in rule 5160:1-3-05.17 of the Administrative Code, and provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

(a) For an annuity to be considered actuarially sound, the total amount of proceeds shall be designed to be dispersed in equal monthly payments with no anticipated lump sum payment. The only allowable lump sum payment is the refund provided when the annuitant dies prior to the end of the guaranteed period and paid to the remainder beneficiary.

(b) The purchased annuity shall not have a balloon payment provision unless the balloon payment designation is for the community spouse.

(c) Any annuity not providing fixed, monthly payments shall be treated as a countable resource. Once annuitized, the annuity will be considered an exempt resource.

(d) Any fixed, monthly payment received from the annuity shall be considered as unearned income to the named annuitant.

(4) Treatment of annuities purchased prior to February 8, 2006.

(a) At any time, any person may use assets of an individual to purchase an annuity that names the individual as the owner and annuitant under the following conditions.

(i) The annuity shall be purchased from a bank, insurance company, or other person engaged in the business of the sale of commercial annuities to the public.

(ii) The annuity may not make payments to other persons during the individual’s life.

(iii) The annuity shall provide for all payments to be made during the life of the annuitant.

(A) To make this determination, the administrative agency shall use the life expectancy tables in rule 5160:1-3-05.17 of the Administrative Code.

(B) If the table indicates that the annuitant will not live as long as the guaranteed period of the annuity, there is an improper transfer.

(C) The amount improperly transferred is the sum of all payments that can be made after the expected end of the life of the annuitant.

(D) The administrative agency shall determine the penalty in accordance with the rules governing improper transfers unless one of the exceptions in rule 5160:1-3-07.2 of the Administrative Code is met.

(E) The individual may also rebut a finding of an improper transfer by establishing that the annuity provides the spouse is the remainder beneficiary, and all remaining payments will occur during the spouse’s life as determined by the life expectancy tables described in rule 5160:1-3-05.17 of the Administrative Code.

(b) Any annuity provided for under paragraph (C)(4)(a) of this rule that has not been annuitized shall be considered an available resource when completing a resource assessment.
An annuity that is making payments in accordance with the provisions in paragraph (C)(4)(a) of this rule, at the time of application for medicaid, shall not be considered an available resource. However, any payments shall be considered unearned income to the annuitant.

An annuity that is not making payments in accordance with the provisions in paragraph (C)(4)(a) of this rule, is considered an available resource if the terms of periodic payments can be changed to conform with the provisions in paragraph (C)(4)(a) of this rule.

If an annuity contains a balloon payment provision, the life expectancy tables described in rule 5160:1-3-05.17 of the Administrative Code may not be used. The value of the balloon payment is considered an improper transfer unless rebutted by the individual. To rebut the presumption, the individual shall produce clear and convincing medical evidence that the annuitant is expected to actually live past the date of the balloon payment.

Private annuity agreements are those not purchased from a bank, insurance company, or other person or entity engaged in the business of the sale of commercial annuities to the public. Assets or resources transferred, used, or otherwise exchanged for a private annuity agreement are considered an improper transfer. However, this is a rebuttable presumption subject to the rules governing improper transfers as delineated in rule 5160:1-3-07.2 of the Administrative Code.

For the purposes of this rule, any improper transfer shall be considered to have occurred on the date of the purchase of the annuity, or on the date after which the terms of periodic payments can no longer be changed to conform with the provisions in paragraph (C)(4)(a) of this rule, whichever is later.

If the individual or the community spouse is the annuitant of an annuity in which neither individual, at any time, held an ownership interest in the funds used to establish the annuity, an improper transfer shall not result if the owner of the annuity fails to make the payments available.

(D) Individual responsibilities.

(1) The individual applying for or receiving long term care services in a long term care facility, under a HCBS waiver program, or under PACE shall disclose any annuity owned by either the institutionalized individual or community spouse.

(2) The individual applying for or receiving long term care services in a long term care facility, under a HCBS waiver program, or under PACE, or the community spouse shall designate the state of Ohio as the remainder beneficiary for any annuity purchased on or after February 8, 2006, as follows:

(a) The state of Ohio is named as the remainder beneficiary in the first position; or

(b) The state of Ohio is named beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such a child disposes of any such remainder for less than fair market value.

(c) The individual is required to provide verification of the remainder beneficiary designation. Failure to provide verification will result in termination or denial for medical assistance.

(E) Administrative agency responsibilities. The administrative agency shall:

(1) Request from the individual a disclosure of any annuity ownership the individual or community spouse has in an annuity for any annuity purchased on or after February 8, 2006.

(2) Explain as part of the application process or upon discovery, such provisions which require the state of Ohio to become a remainder beneficiary for any annuity purchased on or after February 8, 2006.
(3) Verify the remainder beneficiary designation for any annuity purchased on or after February 8, 2006.

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(A) This rule describes the treatment of cash, checking and savings accounts, and time deposits for purposes of determining eligibility for medical assistance.

(B) Definitions.

1. "Cash" means money on hand or available in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for U.S. currency.
   a. Monthly income is not counted when evaluating cash on hand.
   b. The individual's statement of actual cash on hand is accepted without verification.

2. "Checking account" or "savings account" is the same as having cash on hand because deposits are payable on demand. An individual should be able to withdraw money from a checking account or savings account on the same day the individual requests it. In a joint account, all funds in the account are a resource of the individual if he has unrestricted access to the funds.

3. "Dedicated account" means an account in a financial institution, the sole purpose of which is to receive and maintain SSI past-due benefits which are required or allowed to be paid into such an account and the use of which is restricted by section 1631(a)(2)(F) of the Social Security Act (as in effect March 1, 2014).

4. "Depository account", for the purpose of this rule, means a checking account, savings account, or time deposit at a financial institution that allows money to be deposited and withdrawn by the account holder.

5. "Depository signature card" means a contract with the financial institution and it shows who has access to the depository account and whether or not the signatures of more than one owner of the depository account are needed to withdraw funds.

6. "Passbook" means a financial institution record which shows deposits, withdrawals, and interest.

7. "Past-due benefits" mean SSI benefits due but unpaid that accrue prior to the month payment was made effectuated, benefits due but unpaid that accrue during a period of suspension from SSI payments for which the individual was subsequently determined to have been eligible, and any adjustment to SSI benefits that results in an accrual of unpaid benefits.

8. "Time deposit" means a contract between an individual and a financial institution whereby the individual agrees to leave funds on deposit for a specified period and the financial institution agrees to pay interest at a specified rate for that period.
   a. Certificates of deposit (CDs) and saving certificates are common forms of time deposits.
   b. Withdrawal of a time deposit before the specified period expires incurs a penalty, which usually is imposed against the principal. This penalty does not prevent the time deposit from being a resource, but does reduce its value as a resource. On rare occasions, the terms of a time deposit will prohibit early withdrawal.

(C) Access to depository accounts.

1. In situations where a depository account is shared with others and the amount of funds has an effect on the individual's eligibility, the administrative agency shall inform the individual that if he or she has restricted access to the depository account by the contract with the financial institution or if a portion of the depository account was contributed by another person, the individual must provide documentation to support his or her case.

2. The depository account signature card will show who has access to the funds. In the absence of the depository account signature card, a statement from the financial institution is acceptable documentation.
(3) If the individual provides documentation that access to the depository account is restricted through the need for the signature of other owners, all of the funds are still considered a resource of the individual unless documentation is provided of the percentage the other owners have contributed.

(a) If the other owners refuse to allow the individual to withdraw funds from the depository account, the individual must provide documentation that the resource is unavailable and take any action necessary to obtain the resource.

(b) If the individual is institutionalized, a determination of whether an improper transfer has occurred must be completed. If the applicant's signature is all that is needed to access the depository account, then the depository account is his or hers in its entirety unless documentation is provided that indicates what percentage of the funds the other person(s) deposited.

(4) When an individual provides documentation that shows another person has an ownership interest in the depository account, then only the portion that the individual contributed shall be considered as a resource.

(a) Interest accrued on the depository account shall be allocated according to the portions of ownership.

(b) Documentation necessary to show that the individual does not own the funds in the depository account includes:

(i) A statement of the individual giving his or her allegation regarding ownership of the funds, the reason for establishing the joint depository account, who made deposits to and withdrawals from the depository account, how withdrawals were spent, etc.; and

(ii) Corroborating statements from the other depository account holder(s); and

(iii) Where ownership for prior periods needs to be established, the evidence must include a financial institution record, income statement or work record. This may result in determinations that the individual owned varying dollar amounts for the prior period.

(5) If the co-holder of the joint depository account is incompetent or a minor, it is unnecessary to obtain a corroborating statement from that person. That person's incompetency or age may be the reason why the claimant is listed as a joint depository account holder. In the event that this occurs, the administrative agency shall:

(a) Obtain a corroborating statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint depository account.

(b) Make the decision without a corroborating statement if there is no third party and document the basis for its decision and why no corroborating statement was obtained.

(6) If following the evaluation of ownership it is determined that the individual's share of the resource is within the allowable limit, assistance can be approved or continued. The individual shall:

(a) Remove his or her assets from the joint depository account within sixty days from the date his or her eligibility is approved; and

(b) Provide documentation that the change has been made.

(7) The name and address of the financial institution, the depository account number, the name(s) on the depository account, and the amount of money in the depository account must be documented in the individual's case record. If the authority to withdraw money from the depository account does not belong to those whose names are shown on the depository account, that fact must also be documented.

(D) Time deposits.
(1) If the owner of a time deposit cannot under any circumstances withdraw it before it matures, it is not a resource. It becomes a resource (not income) on the date it matures, and may affect countable resources in the month in which the time deposit matures. If the owner has no access to the interest before the time deposit matures, accrued interest is not a resource and is income in the month the deposit matures.

(2) If an individual has transferred his or her resources into a time deposit in which early withdrawal is prohibited, a determination of whether an improper transfer has occurred must be completed. The determination should include consideration of the length of the period of inaccessibility, the individual's life expectancy and the amount of the time deposit.

(3) A time deposit for which early withdrawal is prohibited is still considered a countable resource for the purposes of completing a resource assessment for an institutionalized individual.

(4) A time deposit's resource value at any given time, if early withdrawal is permitted, is the amount the owner would receive upon withdrawing it at that time, excluding interest paid that month. Generally, this is the amount originally deposited; plus accrued interest for past months; minus any penalty specified on the time deposit certificate for early withdrawal.

(E) Verifying depository accounts.

(1) A checking account is verified by examining the printout from online banking or the last monthly bank statement and the checkbook record to arrive at the current bank balance. A copy of the monthly bank statement and check register should be retained in the case record.
   (a) If the printout or statement shows deposit and withdrawal activity or cash flow inconsistent with the individual's stated financial situation, the case shall be investigated carefully to establish the source of income. The administrative agency shall document whether large withdrawals or checks written actually transferred funds to another person or whether such funds are still available to the individual.
   (b) If the printout, bank statement or checkbook is not available or there is some reason to doubt the accuracy of the checkbook record, verification shall be obtained by contact with the financial institution after securing the individual's written authorization.

(2) A savings account is verified by examining the printout from online banking or current balance of the passbook.
   (a) The administrative agency shall retain a copy of the the page(s) that show activity in the last sixty days. If the printout or passbook shows deposit and withdrawal activity inconsistent with the individual's stated financial situation, the administrative agency shall investigate fully to establish the source of income.
   (b) If the printout or passbook is not available or appears to have been materially altered, the administrative agency shall obtain verification by contact with the financial institution after securing the individual's written authorization.
   (c) All the information obtained shall be retained in the individual's case record.
   (d) For nonpassbook savings, the most recent statement or other record of the account in the individual's possession shall be retained in the case record.

(3) A time deposit is verified by viewing the time deposit certificate or document and the account records of interest accrual. The administrative agency may also obtain verification of the time deposit or early withdrawal provisions by contacting the financial institution after securing the individual's authorization. All the information obtained shall be retained in the individual's case record.

(F) Dedicated account.

(1) Past-due benefits and other underpayments that exceed six times the monthly SSI payment deposited into a dedicated financial institution account and any accrued interest or other earnings on such an account are excluded from income and resources.
For any month that funds other than accrued interest or other earnings on the account are commingled in this account, the exclusion does not apply to any funds in the account.

(a) An exception is if the financial institution requires the individual to deposit money to open an account, such as a minimum deposit, a small amount of other funds can be used to open the dedicated account.

(i) The funds that were used to open the account are not excluded as a resource and must be removed from the account once the account has been established and the past-due benefits paid into it.

(ii) The funds that were used to open the account must be withdrawn before the end of the month following the month that the past-due benefits are paid.

(b) Funds other than those described in paragraph (F)(2)(a) shall not be deposited into a dedicated account.

The individual must provide verification that a dedicated account has been established. The verification should include the name and address of the financial institution, account number, account title, type of account, and the amount of money in the account.

The individual's representative payee shall use funds in the account to pay for the following allowable expenses: education or job skills training, personal needs assistance, special equipment, housing modification, medical treatment, therapy or rehabilitation, or any other item or service that the commission for social security determines to be appropriate provided that such expense benefits the individual and, in the case of personal needs assistance, special equipment, housing modification, therapy or rehabilitation or other approved item, is related to the impairment (or combination of impairments) of the individual. These expenditures do not affect an individual's income or resources.

Restrictions on the use of funds in a dedicated account continue to apply during a period of suspension from SSI payments, non-pay status, and SSI eligibility but no payment.

(a) The exclusion from resources of the funds in the account continues to apply until SSI eligibility is terminated.

(b) Once an individual's eligibility has been terminated, the exclusion of the funds in a dedicated account cannot be carried over if the individual establishes a new period of SSI eligibility by filing a new application for SSI.

(c) Reopening of a prior period of eligibility following termination is not a new period of eligibility and, therefore, the exclusion may be reapplied.

(d) Any remaining funds are a countable resource.

When an individual receives past-due benefits that are less than or equal to six times the monthly SSI payment that may be, but have not yet been, deposited into a dedicated account, the payment is excluded from resources for nine months until the payee deposits the payment into a dedicated account. Such payments are not required to be deposited into a dedicated account at the option of the representative payee.
MEMTL 87

Effective Date: October 2, 2014

(A) This rule describes the treatment of promissory notes, mortgages, stocks, bonds and loans for purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Assets" is defined in rule 5160:1-3-05.1 of the Administrative Code.

(2) "Look-back period" is defined in rule 5160:1-3-07.2 of the Administrative Code.

(3) "Mortgage" means a pledge of a particular property for the payment of a debt or the performance of some other obligation within a prescribed time period.

(4) "Promissory note" means a written, unconditional promise signed by a person to pay a specified sum of money at a specified time, or on demand, to the person, corporation, or institution named on the note. A promissory note making periodic payments is not considered an annuity.

(5) "Value of a promissory note" means the outstanding balance due as of the date of the individual's application for medical assistance.

(C) Promissory notes held by an individual.

(1) A promissory note is an available resource unless it cannot be sold.

(2) If the terms of the promissory note prohibit or prevent the sale of the note, the assets given in exchange for the note must be considered improperly transferred, in accordance with the transfer of resources rule Chapter 5160:1-3-07.2 of the Administrative Code.

(a) The total value of resources improperly transferred is the value of the assets originally exchanged for the note, reduced by the sum total of any repayments made on or before the date of application for medical assistance.

(b) The restricted medicaid coverage period shall not be reduced based upon anticipated, estimated, or projected future payments made under the note.

(c) The individual may seek a new eligibility determination and/or a recalculation of the restricted medicaid coverage period based upon actual repayments made under the terms of the note.

(d) If the sum total of all repayments made under the note is less than the original value of the assets given in exchange for the note, the difference will be considered improperly transferred.

(3) Payments received by an individual under a promissory note are treated as income, as defined in Chapter 5160:1-3 of the Administrative Code.

(4) If the individual sells a promissory note for an amount less than the value of assets given in exchange for the note, the difference will be considered improperly transferred as of the note's sale date. The individual may rebut the findings of an improper transfer by:

(a) Providing credible evidence from a knowledgeable source establishing the market value was less than its outstanding principal balance. The knowledgeable source must:

(i) Be clearly identified; and

(ii) Provide a written explanation regarding its opinion of the market value; and

(iii) Affirmatively indicate the decreased market value was not caused in whole or part by the terms of the note and the decrease in value was entirely outside the control of the individual or the individual's representative(s).
Providing documentation clearly showing the individual received payments under the terms of the note prior to the sale, and such payments equal or exceed the difference between the sale price and the value of assets originally given in exchange for the note; or

(c) Providing documentation clearly showing that the lower price of the note was accepted by the individual as payment of a debt owed by the individual to the purchaser.

(5) Documentation must be provided by the individual verifying his or her proportionate share of the note if ownership of the note is shared.

(6) A promissory note has no value if the individual adequately documents the obligations under the promissory note were discharged by order of a bankruptcy court.

(D) Mortgages held by an individual.

(1) A mortgage is an available resource unless it cannot be sold.

(2) The assets given in exchange for the mortgage will be considered improperly transferred if the terms of the mortgage prohibit or prevent the sale of the mortgage in accordance with the transfer of resources rule Chapter 5160:1-3-07.2 of the Administrative Code.

(3) Any payments made under a mortgage must be treated as income, as defined in Chapter 5160:1-3 of the Administrative Code.

(4) A copy of the property agreement must be recorded with the county auditor, county recorder, or other appropriate government agency charged with the responsibility of recording property agreements.

(a) For the purposes of this rule, a property agreement is not considered effective until the date it is recorded with the county auditor, county recorder, or other appropriate government agency charged with the responsibility of recording property agreements. The administrative agency shall disregard any property agreement that is not properly recorded and shall consider the entire property as an available resource to the individual.

(b) For the purposes of this rule, the property agreement recording date held by the appropriate government agency is considered the date of transfer.

(5) For an individual selling a mortgage for an amount less than the value of assets given in exchange for the mortgage, the difference shall be considered improperly transferred as of the mortgage sale date. The individual may rebut the findings of an improper transfer by:

(a) Providing credible evidence from a knowledgeable source establishing the fair market value at the mortgage’s sale date was less than its outstanding principal balance. The knowledgeable source must:

   (i) Be clearly identified; and

   (ii) Provide a written explanation regarding its opinion of the market value; and

   (iii) Affirmatively indicate that the decreased market value was not caused in whole or part by the terms of the mortgage and that the decrease in value was entirely outside the control of the individual or the individual's representative(s).

(b) Providing documentation clearly showing the individual received payments under the terms of the mortgage prior to the sale, and such payments equal or exceed the difference between the sale price and the value of assets originally given in exchange for the mortgage; or

(c) Providing documentation clearly showing that the lower sale price of the mortgage was accepted by the individual as payment of a debt owed by the individual to the purchaser.

(6) Documentation must be provided by the individual verifying his or her proportionate share of the mortgage if ownership of the mortgage is shared.
Proceeds from reverse mortgages or home equity conversion programs are excluded income in the month of receipt. Proceeds retained until the month following the month of receipt are subject to evaluation as a resource, in accordance with Chapter 5160:1-3 of the Administrative Code.

The value of a mortgage is the outstanding balance due as of the individual's application date for medical assistance.

A mortgage will have no value if the individual adequately documents the obligations under the mortgage were discharged by order of a bankruptcy court.

Loans held by an individual.

Money an individual borrows or money received as the principal repayment of a bona fide loan is not considered income.

(a) Any interest received on money loaned is unearned income.

(b) Retained proceeds of a loan in the month following the month of receipt are counted as a resource.

The value of the loan is the outstanding balance due as of the individual's application date for medical assistance.

Funds used to purchase a promissory note, mortgage or loan.

With respect to a transfer of assets, as referenced in rule 5160:1-3-07.2 of the Administrative Code, funds used to purchase a promissory note, mortgage or loan are considered an asset unless the promissory note, mortgage or loan:

(a) Has a repayment term that is actuarially sound as determined in accordance with actuarial publications of the office of the chief actuary in 26 C.F.R. 20.2031-7 (as in effect December 1, 2013);

(b) Provides for payments made in equal amounts during the term of the promissory note, mortgage or loan, with no deferral and no balloon payments made; and

(c) Prohibits the cancellation of the balance upon the lender's death.

Stocks held by an individual, including preferred stocks, warrants and rights, and stock option purchases.

Stock shares represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely.

The current market value of publicly traded stock is its closing price. The stock closing price, on a given day, can usually be found in the next day's regulator or financial newspaper. The value of over-the-counter stocks are shown on a "bid" and "asked" basis. The bid price is used to determine the stock's value.

(a) If the closing or bid price of a stock is not shown, a local securities firm must determine its value. If the ownership of the stock is shared (i.e., more than one name is on the face of the stock certificate), the individual must provide documentation verifying the individual's proportionate stock share.

(b) The stock of some corporations is not publicly traded and is held within close groups and traded very infrequently. The sale of such stock is often handled privately and subject to restrictions. The burden of proof for establishing the value of this kind of stock is on the individual. The preferred evidence is a letter or other written statement from the firm's accountants giving their best estimate of the stock's value and the basis for the estimate, and can include the most recent sale, the most recent offer from outsiders, the current market value of assets less debts on them, cessation of activity and sale of assets, and bankruptcy.
(3) The county prosecutor or the administrative agency’s legal staff shall be consulted for assistance in determining the value of the stock when the verification of the current value of the stock of a closely held corporation is questionable, including when there are indications that the extent of an individual's ownership is being manipulated to reduce the value of the stock as a countable resource.

(4) Shares of stock in an Alaskan native regional or village corporation, as defined in 43 U.S.C. 1601 - 1624 (as in effect on December 1, 2013), are excluded from resources.

(H) A mutual fund is determined in the same manner as the value of a stock.

(I) The current cash value of a municipal, corporate, or government bond is counted as a resource. If the ownership of a bond is shared, the individual must provide documentation verifying the individual's proportionate share of the bond.

(J) The current redemption value of a U.S. savings bond is a countable resource. The individual must provide documentation verifying the individual's proportionate share of the bonds if the bonds are jointly owned.

Replaces: 5160:1-3-27.3
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Rule Amplies: 5160.02, 5163.02
MEMTL 87

Effective Date: October 2, 2014

(A) This rule describes the treatment of preneed funeral contracts for purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Liquid assets" means cash or property immediately convertible to cash.

(2) "Preneed funeral contract" means an agreement whereby the buyer pays in advance for a burial that the seller agrees to furnish upon the death of the buyer or other designated individual.

(C) Irrevocable preneed funeral contracts.

(1) Irrevocable preneed funeral contracts are not a resource.

(2) Increases in the value of irrevocable preneed funeral contracts which result from accrual on interest or from appreciation in the value of the preneed burial agreement are excluded from countable resources.

(D) Revocable or salable preneed funeral contracts.

(1) If a preneed funeral contract is revocable or salable it is a countable resource.

(2) The value of a revocable or salable funeral contract is:

   (a) The amount payable to the buyer upon revocation; or

   (b) The current market value.

(3) Revocable preneed funeral contracts and burial vault contracts payable on demand are considered liquid assets. Their value, when combined with all other countable resources, cannot exceed the resource limit.

(E) Purchase of burial space. Any portion of the contract that clearly represents the purchase of a burial space is excludable as a countable resource if it meets the requirements of rule 5160:1-3-05.7 of the Administrative Code.

(F) Life insurance funded preneed funeral contracts

(1) A life insurance funded preneed funeral contract involves an individual owning/purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a preneed funeral contract.

(2) For medical assistance purposes, the ownership of a life insurance policy may be irrevocably changed to a financial institution or a provider of funeral services for the specific use as an irrevocable preneed funeral contract for the individual and/or spouse.

   (a) To determine if the transfer of ownership of a life insurance policy to an irrevocably transferred policy has been completed, the administrative agency must review and maintain in the case record all of the following items:

      (i) The life insurance policy.

      (ii) Preneed funeral contract. The preneed funeral contract must have a fair market value equal to the face value of the policy that has been irrevocably transferred or assigned.

      (iii) For medical assistance purposes, for a preneed funeral contract that is funded by a life insurance policy, the funeral provider can stipulate in the preneed funeral contract that goods and services will be provided commensurate with the amount of insurance proceeds that are available at the time the services are required.
(iv) Completed legal document changing irrevocable ownership of the policy to the financial institution or funeral provider. Verification that the change of ownership has been completed must be obtained from the insurer.

(v) A provision in the contract that the funeral provider has the irrevocable right to the proceeds of the life insurance policy upon the death of the insured.

(vi) At the time of death, the cash surrender value (CSV) of the policy may exceed the cost of the preneed funeral contract or expenses. The preneed funeral contract must include a provision that any funds in excess of the costs will be paid to the deceased individual's estate. Probate court must decide how these funds are dispersed. If the administrative agency is contacted by the funeral director regarding these funds, the administrative agency must direct them to the appropriate probate court.

(b) The transfer of ownership must be verified by the insurer that the insurer has, in fact, changed ownership of the policy.

(i) For the purpose of determining eligibility for medical assistance, the CSV of the policy will not be considered a countable resource effective on the date of the change of ownership. The date of the change of ownership will be considered the later of the dates that the irrevocable change of ownership paperwork and the preneed funeral contract were signed by the owner of the policy and the funeral provider if both were not signed on the same date.

(ii) Verification must be provided to the administrative agency verifying the change of ownership has been acknowledged and completed by the insurer before paragraph (F)(2)(b)(i) of this rule can be implemented.

(c) A change of beneficiary, whether irrevocable or not, of a life insurance policy does not satisfy the requirement of an irrevocable change of ownership.

(3) Dividend accumulations of a life insurance policy as part of the value of the policy or the preneed funeral contract are not excluded. Dividend accumulations are separate resources and must be designated separately in order to qualify for the burial funds exclusion.
Effective Date: October 2, 2014

(A) This rule describes the treatment of burial spaces for the purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Agreement", for the purpose of this rule, means a contract with a burial provider for a burial space held for the eligible individual or a member of his/her immediate family.

   (a) An individual's immediate family includes his parents, including adoptive parents, minor or adult children, including adoptive and stepchildren, siblings, including adoptive and stepsiblings and the spouses of the immediate family members.

   (b) In order for the burial space exclusion to apply to spouses of the immediate family members, the marriage must be in effect at the time of determination or redetermination of eligibility for medical assistance.

(2) "Burial space", means a burial plot, gravesite, crypt, mausoleum, casket, urn, niche, or other repository customarily and traditionally used for the deceased's bodily remains. The term also includes a contract for care and maintenance of the gravesite, sometimes referred to as an endowment or perpetual care and necessary and reasonable improvements or additions to such spaces, including but not limited to vaults, headstones, markers, or plaques, burial containers (e.g., for caskets) and arrangements for the opening and closing of the gravesite.

(C) An agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value. For example, exclude a cemetery lot and a casket for the same person, but not a casket and an urn.

(D) A burial space is held for an individual when someone currently has title to and/or possesses a burial space intended for the individual's use (e.g., has title to a burial plot or owns a burial urn stored in the basement for his own use) or a contract with a funeral service company for specified burial spaces for the individual's burial (i.e., an agreement which represents the individual's current right to the use of the items at the amount shown).

(E) Until the purchase price is paid in full, a burial space is not held for an individual under an installment sales contract or similar device.

(F) Administrative agency responsibilities. The administrative agency shall:

   (1) Determine whether the burial space is held for the individual or member of the individual's immediate family if the agreement shows the purchase of a specified burial space at a specified price.

   (2) Of items that serve the same purpose, exclude only one per person.

   (3) If the agreement calls for installment payments, determine whether the value of the burial space must be treated as an available resource.
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
This rule describes the treatment of lump-sum payments for purposes of determining eligibility for medical assistance.

Definition. "Lump-sum payment" means income which is accrued over two or more months or it is a money payment which is not related to any time period, such as a death benefit or inheritance.

A nonrecurring lump-sum payment is considered unearned income unless otherwise excluded. It is unearned income in the month received and a countable resource in the month following the month of receipt.

The following are some types of lump-sum payments that are considered unearned income:

(a) Gifts, prizes, or awards.
(b) Retirement or pension funds
(c) Judgments and out-of-court settlements.
(d) Proceeds received as the beneficiary of a life insurance policy, including social security lump-sum death benefits.
(e) Workers compensation payments when received as a lump-sum.

The following are some types of lump-sum payments that are considered resources, that are not unearned income:

(a) Income and property tax refunds.
(b) Proceeds received from the surrender or maturing of insurance policies.
(c) Proceeds received for the sale of real property.
(d) Replacement of income that was lost, destroyed or stolen if the original income was used to determine eligibility.

The transfer of a lump sum in the month of receipt or anytime thereafter is subject to the regulations in rule 5160:1-3-07.2 of the Administrative Code relating to transfers of resources.

Retroactive payments from supplemental security income (SSI) or retirement, survivors, disability insurance (RSDI) are unearned income in the month received and excluded as countable resources for six months following the month of receipt. The source, amount, and the date of receipt of the retroactive payment must be verified and the information recorded in the case record.

As long as the funds from the retroactive payment are not spent, they are excluded for the full six month period. Unspent money must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds, but if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit.

Once the money is spent, this exclusion does not apply to items purchased with the money even if the six month period has not expired. However, other exclusions may apply.

When a medicaid individual, including a nursing home or home and community-based services waiver (HCBS) individual receives a lump-sum payment, he or she may increase his or her personal property holdings up to the maximums allowed. Then the CDJFS compares the amount received to the amount of medicaid payments made on behalf of the individual.

If the lump sum is equal to or less than medicaid payments for the individual, the individual is given a choice of either:
(a) Terminating assistance and reapplying when resources are again within allowable limits; or,

(b) Repaying the medicaid program for medicaid payments made on his or her behalf in order to preserve continuing medicaid eligibility. The amount paid by medicaid for past care can be recovered only if the individual agrees and if the repayment amount will continue to make him or her eligible for medicaid.

(2) If the lump sum is in excess of past medicaid payments made on the individual's behalf, the excess amount shall be counted as an available resource. If the amount exceeds the maximum resource limit, the case shall be terminated. In this situation, the individual is not required to use any of the lump sum as repayment of past medicaid payments.

(G) Lump-sum payments received by an individual that are the result of a medical insurance policy that pays an individual directly rather than the providers for services when the individual is hospitalized or in a long term facility are assignable to the Ohio department of medicaid as reimbursement for past medical care, up to the amount that has been paid by medicaid.

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MEMTL 87

Effective Date: October 2, 2014

(A) This rule describes the treatment of dividends and interest for the purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Dividends" and "interest", for the purpose of this rule, are returns on financial institution accounts. A cash gift or incentive payment to open an account is considered interest.

(2) "Financial institution account", for the purpose of this rule, is an individual or joint account such as checking or savings, certificate of deposit, stocks, bonds, etc..

(C) Accrued dividends and interest on financial institution accounts are added to the principal and the total is evaluated as a resource.

Replaces: 5160:1-3-27.6
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MEMTL 87

Effective Date: October 2, 2014

(A) This rule describes the treatment of household goods and personal effects for the purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Household goods", for the purpose of this rule, are all personal property customarily found in the home and used in connection with the maintenance, use and occupancy of the premises. This encompasses items necessary for an adequate standard of sustenance, accommodation, comfort, information and entertainment of occupants and guests. Such items include furniture, furnishings, linens, household appliances, carpets, dishes, cooking and eating utensils, televisions and personal computers.

(2) "Personal effects, for the purpose of this rule, are other personal property normally held and recognized as incidental items intended for personal use by one or more household members. Such items include clothing, jewelry, watches, personal grooming articles and musical instruments.

(C) Household goods and personal effects are excluded as resources.

(D) Items acquired or are held for their value or as an investment are not considered personal effects and are countable resources. Such items can include but are not limited to gems, jewelry that is not worn or held for family significance, or collectibles.

Replaces: 5160:1-3-28

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MEMTL 87

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(A) This rule describes the treatment of automobiles and other modes of transportation for purposes of determining eligibility for medical assistance.

(B) Definition. "Automobile", for the purpose of this rule, means any vehicle used for transportation. It can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and even animals.

(C) One automobile is excluded for the individual or a member of the individual's household regardless of value if it is: necessary for employment; necessary for the treatment of specific or regular medical problems; modified for operation by, or the transportation of, a handicapped person; or necessary, because of climate, terrain, distance or similar factors, for the performance of essential daily activities.

(1) For the purposes of determining the resource assessment for couples when one spouse is institutionalized, one automobile is considered totally excluded, regardless of its use and value in accordance with rule 5160:1-3-06.2 of the Administrative Code.

(2) If no automobile is excluded for one of the above listed reasons, up to four thousand five hundred dollars of the current market value of one automobile is excluded. If the current market value exceeds four thousand five hundred dollars, the excess counts as a resource unless the automobile can be excluded under some other rule. Equity value is not a consideration for purposes of this exclusion.

(3) Any automobile an individual owns in addition to the one wholly or partly excluded and which cannot be excluded under another rule (e.g., property essential for self-support) is a resource in the amount of its equity value.

(4) If one of two cars can be excluded because of one of the reasons listed above, and the other is a countable resource, the exclusion applies to the car with the greater equity value regardless of which car is actually used.

(5) The equity value is counted for all additional automobiles, regardless of the type of vehicle (e.g., automobiles, boats, etc.), is counted as a resource.

(6) The equity value for all vehicles that are not used for transportation (e.g., pleasure boats, snowmobiles, etc.) or excluded under another rule (e.g., necessary for self-employment) is counted as a resource. These vehicles are considered countable, not excludable, personal property.

(D) For the purpose of determining whether a vehicle is used for transportation (i.e., whether it is an automobile for medicaid purposes), accept the individual's account of its use unless a question arises. If a vehicle is not being used for transportation, find out why.

(1) A temporarily broken-down vehicle normally used for transportation still qualifies as an automobile. One that has been junked or that is used only as a recreational vehicle (e.g., a boat used weekends on the lake) does not qualify as an automobile.

(2) Vehicles that do not meet the definition of an automobile are personal property. The value they have as a resource is their equity value, and the personal effects exclusion, described in rule 5160:1-3-05.10 of the Administrative Code, does not apply to them.

(E) The current market value of an automobile is determined by the average trade-in value shown for the vehicle in the most recently published "National Automobile Dealers Association (NADA) Guide". The description of the car must be complete enough to enable the administrative agency to find it in the appropriate NADA guide. The description should include the year, make, model, number of doors, equipment, etc. Absent evidence to the contrary, assume the vehicle to be in average condition.

(1) If the NADA guide cannot be used (e.g., animal-drawn vehicle), obtain a current market value estimate from a disinterested knowledgeable source.
An individual who disagrees with the value of the vehicle can rebut the value by obtaining a written appraisal of the vehicle’s current market value from a disinterested knowledgeable source, such as a used car or truck dealer or an automobile insurance company. The administrative agency is not bound by this appraisal but the appraisal should be considered in the evaluation of the vehicle.

Always verify the collector value of an antique or other collectible vehicle.

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MEMTL 87

Effective Date: October 2, 2014

(A) This rule describes how life insurance policies are treated for purposes of determining medical assistance eligibility.

(B) Definitions of terms contained within life insurance policies.

(1) "Accelerated life insurance payments" means proceeds paid to a policyholder prior to death. Although accelerated payment plans vary from company to company, all of the plans involve early payout of some or all of the proceeds of the policy.

(2) "Beneficiary" means an individual or entity named in the contract to receive the policy proceeds upon the death of the insured.

(3) "Cash surrender value (CSV)" means a form of equity value that the policy acquires over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV. The value usually increases with the age of the policy.

(4) "Dividend additions" and "dividend accumulations" mean amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV.

(a) Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV. The table of CSV's that comes with a policy does not reflect the added CSV of any dividend additions.

(b) Dividend accumulations are dividends that the policy owner has constructively received but left in the custody of the insurer to accumulate an interest, like money in a bank account. They are not a value of the policy per se; the owner can obtain them at any time without affecting the policy's face value (FV) or CSV. Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision, they are a countable resource.

(5) "Dividends", for the purpose of this rule, means periodically (annually, as a rule), the insurer may pay a share of any surplus company earnings to the policy owner as a dividend. Depending on the life insurance company and type of policy involved, dividends can be applied to premiums due or paid by check to the owner or by an addition or accumulation to an existing policy.

(6) "Face value" (FV) means the amount of basic death benefit contracted for at the time the policy is purchased.

(7) "Insured" means the individual whose life is covered by the life insurance policy.

(8) "Insurer" means the company or association which contracts with the owner.

(9) "A life insurance policy" means a contract under which the insurer agrees to pay a specified amount to a designated beneficiary upon the death of the insured.

(10) "Owner" means the individual with the right to change such policy. It is normally the person who pays the premiums.

(11) A "supplementary contract" is not a life insurance policy. It is an agreement whereby, when the policy matures or the insured dies, the proceeds are paid not in a lump sum, but in an alternative manner selected by the individual, usually as an annuity. A supplementary contract must be evaluated as a potential source of income that the individual must avail themselves of as outlined in rule 5160:1-3-03.1 of the Administrative Code.
A life insurance policy is a countable resource for medical assistance purposes if it generates a CSV. Its value as a resource is the amount of the CSV.

1. The total CSV of all life insurance policies for an individual is excluded if the total face value of the policies is equal to or less than one thousand five hundred dollars for any one individual. If the total face value of all life insurance policies for any one individual is more than one thousand five hundred dollars, then the total CSV of all the policies for that individual is counted toward the applicable resource limit. Policies in which a CSV has not yet accrued are still considered available when determining the total face value of the individual's life insurance policies.

2. Life insurance policies in which no CSV will ever accrue (e.g., term insurance), are not considered in determining the face value of the insurance policies, and are excluded from all computations. In addition, burial insurance policies are not considered in computing face value. Burial insurance is insurance which by its terms can only be used to pay the burial expense of the insured and will not accrue any CSV.

3. When the face value of all countable life insurance policies on an ineligible individual exceeds one thousand five hundred dollars and deeming is required, the cash value of the policies is combined with the ineligible individual’s other countable resources and appropriately deemed to the eligible individual.

D. The individual must submit all policies that the individual and spouse own. The following information must be recorded in the case record:

1. Name of insured;
2. Name of owner;
3. Type of insurance (ordinary [whole], life or term);
4. Face value;
5. For ordinary life, cash surrender value;
6. For ordinary life, amount of loans outstanding against the policy;
7. For term insurance, amount of premium and frequency;
8. Name of company;
9. Policy number;

E. The following factors are considered to determine whether a life insurance policy is a resource:

1. If the policy does not have a CSV due to the type of policy, further examination is not necessary. If the policy does have a CSV, the administrative agency must distinguish between the owner of the policy and the insured.

2. The owner of the policy is the only individual who can receive the proceeds under the cash surrender provisions of the policy. Therefore, it is not material that the individual (or spouse) is the insured individual if the individual is not also the owner of the policy. If this is the case, there is no resource available.

3. A life insurance policy is an available resource only when the policy is owned by the individual or person whose resources are deemed to the individual. If the consent of another person is needed to surrender a policy for its full CSV, the policy is available as a resource after the individual has obtained the consent. The individual must make a reasonable effort to obtain consent. If the consent cannot be obtained, the policy is not available. Any doubt about possible availability is resolved by contacting the insurance company. A determination would need to be made as to whether an improper transfer had occurred.

4. The exclusion of a total of one thousand five hundred dollars face value of countable insurance policies applies to each individual separately and does not mean an average of one thousand five hundred dollars per person. An individual and spouse are each allowed one thousand five hundred dollars but not any combination of values for a three thousand dollar total for both.
(5) CSV of a policy is determined by contacting the insurance company whenever there is any question regarding the current value.

(6) The insurance exclusion does not apply to a matured endowment policy since the owner may elect to receive the total face value at any time. If the individual leaves the matured policy on deposit with the insurance company, it is no longer classified as insurance but is considered a liquid asset, an investment at interest (the same as money in a savings account).

(F) Evaluating the insurance policy.

(1) Face value. The face value on the insurance policy may be labeled the "face amount," "sum insured," "amount of insurance" or "amount of this policy."
   (a) The face value does not include additional benefits payable because of special conditions such as double indemnity riders, which apply in the event of accidental death.
   (b) If the face value cannot be determined, the insurance company or local agent is contacted for clarification. For example, the insurance company must clarify the value when there has been a lapse in the policy because of nonpayment of premiums which results in some other insurance option becoming effective. If the information is obtained by telephone, the name, title and telephone number of the person contacted, and the name and address of the insurance company and the details of the conversation are documented in the case record.

(2) Cash surrender value. To compute the cash surrender value of a life insurance policy, it is necessary to know whether the premiums are up-to-date or in default (have not been paid) and to read the conditions in the policy affecting cash surrender. The anniversary date of a policy is the same day and month as the date of issuance. Verification of the cash surrender value must be obtained from the insurance company if the CSV, on its own, or in conjunction with other resources is close to the applicable resource limit.

(3) An owner's failure to pay the premiums on the life insurance policy or failure to elect an option within a certain period of time after defaulting on the premiums generally causes an option to apply automatically. The CSV is usually applied by the company along with any dividends to buy extended life insurance. Under these circumstances, the face amount of the life insurance is uncertain and there is a possibility that a certain option or options have come into play. It is necessary for the insurance company to compute the actual CSV before a determination of eligibility can be made. The current face value and CSV must be obtained from the insurance company.

(4) When an individual has borrowed on a life insurance policy, the amount of the CSV depends upon the outstanding loan. Under these circumstances, the administrative agency must contact the insurance company to determine the amount of the CSV.

(G) Treatment of accelerated life insurance payments.

(1) Most accelerated payment plans fall into three basic types, depending on the circumstances which cause or trigger the payments to be accelerated. These types are the following:
   (a) Long term care model, which allows the policyholders to access their death benefits should they require extended confinement in a care facility or, in some instances, health care services at home;
   (b) Dread disease or catastrophic illness model, which allows policyholders to access their death benefits if they contract or acquire one of a number of specified covered conditions; and
   (c) Terminal illness model, which allows policyholders to access their death benefits following a diagnosis of terminal illness where death is likely to occur within a specified number of months.

(2) Some companies refer to these types of payments as "living needs" or "accelerated death" payments.
Depending on the type of accelerated payment plan, receipt of accelerated payments may reduce the policy's face value by the amount of the payments and may reduce the CSV in a manner proportionate to the reduction in face value. In some cases, a lien may be attached to the policy in the amount of the accelerated payments and a proportionate reduction in CSV results.

Accelerated payments are not "benefits" for purposes of exploring potential income. It is not required that a policyholder apply for accelerated payments as a condition of obtaining or retaining medical assistance eligibility.

Since accelerated payments can be used to meet food or shelter needs, the payments are income in the month received and a resource if retained into the following month and not otherwise excludable.

The receipt of an accelerated payment is not treated as a conversion of a resource for medicaid purposes. This is because, under an accelerated arrangement, an individual receives proceeds from the policy, not the policy's resource value, which is its CSV.

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MEMTL 87

Effective Date: October 2, 2014

(A) This rule describes the treatment of an individual's home for purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Home", for the purpose of this rule, means any property in which an individual has an ownership interest in and which serves as the individual's principal place of residence. Home includes the structures and land appertaining to the home property. Appertaining land must be contiguous to adjoin the land on which the home property is located and must not be separated by intervening land property owned by others.

(2) "Home equity limit" means, for applications filed on or after January 1, 2006, the maximum amount of equity which an individual could have in a home and remain eligible for long-term care facility (LTCF) services, home and community based services (HCBS) waiver or program of all inclusive care for the elderly (PACE) services. The home equity limit of five hundred thousand dollars will increase annually beginning January 1, 2011, as established by section 5163.32 of the Revised Code.

(3) "Nursing facility", for the purpose of this rule, refers to a nursing facility, intermediate care facility for individuals with intellectual disabilities, or other medical institutions.

(4) "Principal place of residence" means the dwelling the individual considers his or her established or principal home and to which, if absent, he or she intends to return. Principal place of residence can be real or personal property, fixed or mobile, and located on land or water.

(5) "Qualified long term care partnership (QLTCP)" is defined in rule 5160:1-3-02.8 of the Administrative Code.

(C) The home lived in, owned by, and considered the principal place of residence by the individual, the couple, or the parents with whom the eligible child is living.

(1) Only one living place may be established as the principal place of residence.

(2) A temporary absence from the home does not affect the principal place of residence exemption so long as the individual intends to return to the home and has not established permanent residence elsewhere.

(3) The administrative agency must obtain a signed statement, declaring the principal place of residence, when there is an indication the individual resides in more than one place.

(D) Treatment of the home when LTCF services, HCBS waiver or PACE services are requested.

(1) For the value of the home to be excluded:

(a) The home must be the individual's or the individual's spouse principal place of residence; and

(b) The deed to the home must be in the individual's or individual's spouse's name; and

(c) The home must comply with the provisions in paragraphs (D)(5) to (D)(7) of this rule.

(2) The home is no longer considered to be the principal place of residence if the individual resides in a nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or other medical institution for a continuous period of thirteen months or longer. The administrative agency must consider the home a countable resource when the individual has continuously resided in a nursing facility, ICF-IID, or other medical institution for thirteen months or longer; however, the home is not a countable resource if any of the following individuals are residing in the home:
(a) The individual's spouse; or
(b) The individual's child who is under age twenty-one, or blind or disabled as defined in Chapter 5160:1-3 of the Administrative Code; or
(c) The individual's child who is age sixty-five or older and is financially dependent upon the individual for housing. Verification of financial dependency in this situation is determined by comparing the aged child's countable income to the Ohio works first (OWF) payment standard defined in Chapter 5101:1-23-20 of the Administrative Code; or
(d) The individual's sibling who has a verified equity and ownership interest in the home and has resided in the home for at least one year immediately before the date the individual was admitted to the nursing facility.

(3) The thirteen month home exclusion period begins the first month in which the individual is both eligible for medicaid and residing in a nursing facility, ICF-IID, or other medical institution.

(4) If a thirteen month home exclusion period is interrupted because the individual has resided in a nursing facility, ICF-MR, or other medical institution for less than thirteen months or the individual is ineligible for medicaid for any month during the thirteen month home exclusion period, then a new thirteen month home exclusion period must begin as outlined in paragraph (D)(2) of this rule.

(5) For applications filed on or after January 1, 2006, an individual is not eligible for LTCF services, a HCBS waiver or PACE if the individual's equity interest in the individual's home exceeds the home equity limit. The home equity limit is applicable even though the home is considered the principal place of residence as defined in this rule.

(a) The equity value in excess of the home equity limit does not apply to an individual if any of the following persons are lawfully residing in the individual's home:
   (i) The individual's spouse; or
   (ii) The individual's child who is under age twenty-one, or blind or disabled as defined in Chapter 5160:1-3 of the Administrative Code.

(b) Nothing in paragraph (D)(5) of this rule should be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home below the home equity limit.

(c) The requirements in this paragraph must be waived in the case of a demonstrated hardship as outlined in paragraph (E) of this rule.

(6) The home equity limit is applicable even when an individual is a recipient of QLTCP benefits. A QLTCP exclusion can not offset or reduce home equity for the purposes of paragraph (D)(5) of this rule.

(7) An individual who applies for and is determined eligible for long-term care (LTC) services before January 1, 2006 is not subject to the home equity limit; however, if the individual has a break in LTC eligibility on or after January 1, 2006, the home equity limit described in paragraph (D)(5) of this rule applies.

(E) Home equity and undue hardship.

(1) The administrative agency must deny or terminate LTC services, HCBS waiver or PACE payment when an individual's equity interest in the individual's home exceeds the home equity limit, with the exception in paragraph (D)(5)(a) of this rule.

(2) The individual will not be subject to a denial or termination of benefits resulting from home equity in excess of the home equity limit if the denial or termination will result in an undue hardship. An undue hardship exists when denial or termination of LTC services, HCBS waiver or PACE would deprive the individual of the following:
   (a) Medical care such that the individual's health or life would be endangered; or
(b) Food, clothing, shelter, or other necessities of life.

(3) The individual must first document an attempt was made to reduce the home equity value below the home equity limit.

(4) An undue hardship exemption may be requested by the individual or, with the consent of the institutionalized individual or the authorized representative, by the nursing facility on behalf of the institutionalized individual.

(5) Undue hardship does not exist when the institutionalized individual has taken action to restrict access to the excess home equity.

(6) For the purpose of this rule, individuals determined to be incompetent, who do not have another individual to act on their behalf, must be referred to the county prosecutor or the administrative agency's own legal staff.

(F) The individual must provide verification, as defined in rules 5160:1-2-08 and 5160:1-2-10 of the Administrative Code.

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MEMTL 87

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(A) This rule describes excluded resources for the purpose of determining medicaid eligibility.

(B) Definition. "Home" is defined in rule 5160:1-3-05.13 of the Administrative Code.

(C) The following are considered excluded resources:

(1) Household goods and personal effects of a reasonable value as described in rule 5160:1-3-05.10 of the Administrative Code.

(2) Automobiles and other modes of transportation as described in rule 5160:1-3-05.11 of the Administrative Code.

(3) Life insurance policies as described in rule 5160:1-3-05.12 of the Administrative Code.

(4) The home considered the principal place of residence as described in rule 5160:1-3-05.13 of the Administrative Code.

(5) Real or personal property considered essential to the means of self-support as described in rule 5160:1-3-05.19 of the Administrative Code.

(6) The value of a burial space as described in rule 5160:1-3-05.7 of the Administrative Code.

(7) Certain preneed funeral contracts as described in rule 5160:1-3-05.6 of the Administrative Code.

(8) Cash or in-kind replacement received from any source for purposes of replacing or repairing an excluded resource which is lost, damaged, or stolen. Any interest earned on such cash payments, is not income. The total amount of cash (including interest earned) or the value of the in-kind replacement is excluded as a resource for a period of nine months from the date of receipt.

(a) If the exclusion time expires and the individual has not used all of the cash, any remaining cash (as well as interest earned on such cash) is a countable resource effective the first day of the following month in which the time period expires.

(b) The exclusion time may be extended for good cause for a reasonable period not to exceed an additional nine months (a total of eighteen months from the date the cash is received).

(c) Good cause may be found if:

(i) The individual made a reasonable effort to contract for or obtain replacement or repair of an excluded resource within the original nine-month period; and

(ii) The individual still intends to use any cash received for that purpose.

(d) Any change of intent, which occurs during the extension period, will cause the exclusion to end. Any cash and interest retained becomes a resource the first day of the month following the month in which the individual reports the change or intent, or the eighteen-month period ends, whichever comes first.

(e) Temporary housing received by an individual whose home was destroyed or damaged is also excluded for a period of nine months beginning with the month the temporary housing is first provided. For purposes of this rule, temporary housing includes the value of support and maintenance. When a home is damaged or destroyed and temporary housing is furnished to an individual who owned the home, any form of in-kind support and maintenance is not counted as income.

(9) Funds held in plans for achieving a self-support (PASS) account in accordance with section 1613(a)(4) of the Social Security Act (as in effect on March 1, 2014).
The accumulation of payments received under the Agent Orange Compensation Exclusion Act, Pub. L. No. 101-201 (as in effect on December 1, 2013) received on or after January 1, 1989.

The accumulation of payments received under section 105 of Pub. L. No. 100-383 (as in effect on December 1, 2013) by individuals of Japanese ancestry.

The accumulation of payments received under section 206 of Pub. L. No. 100-383 (as in effect on December 1, 2013) by Aleuts.

The accumulation of German reparation (restitution) payments paid under the republic of Germany's federal law for compensation of nationalist socialist persecution to certain surviving victims of Nazi persecution, per Pub. L. No. 103-286 (as in effect on December 1, 2013).

The accumulation of payments received under the Radiation Exposure Compensation Act, Pub. L. No. 101-426 (as in effect on December 1, 2013).

Federal earned income tax credit payments, either refunded or advanced by an employer, are excluded for nine months beginning after the month of receipt in accordance with section 1613(a)(11) of the Social Security Act (as in effect on March 1, 2014).

The accumulation of payments received under the Maine Indian Claims Settlement Act, Pub. L. No. 96-420 (as in effect on March 1, 2014) received on or after October 10, 1980.

The accumulation of Austrian social insurance payments paid under paragraphs 500 and 506 of the Austrian General Social Insurance Act (as in effect on December 1, 2013).

The accumulation of payments received under the Aroostook Bank of Micmacs Act, Pub. L. No. 102-171 (as in effect on March 1, 2014) received on or after November 26, 1991.

The accumulation of payments received under the Seneca Nation Settlement Act, Pub. L. No. 101-503 (as in effect on December 1, 2013) received on or after November 3, 1990.

The accumulation of payments received as a result of the Netherlands' Act on Benefits for Victims of Persecution (1940-1945) (as in effect on December 1, 2013).


Past-due benefits and other underpayments that exceed six times the monthly SSI payment deposited into a dedicated financial institution account and any accrued interest or other earnings on such an account are excluded as income and resources as defined in rule 5160:1-3-05.4 of the Administrative Code.

Any interests of the individual (or spouse) in trust or restricted lands, in accordance with 20 C.F.R. 416.1234 (as in effect on December 1, 2013) if an individual or an individual's spouse is of native American Indian descent from a federally recognized native American Indian tribe. If an individual alleges an interest in trust or restricted lands, the administrative agency must obtain a copy of any document or documents that identify such interest and verify the allegation with the appropriate Indian agency.

Assistance received as a result of a catastrophe declared by the president of the United States as a major disaster, no matter if received from federal, state, or local government, or from a disaster assistance organization. This includes any interest earned on the assistance.

Any unspent payments received from a fund established by a state to aid victims of crime are excluded for nine months beginning after the month of receipt as identified in section 5031 of Pub. L. No. 101-508 (as in effect on December 1, 2013).

Relocation assistance, under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, 42 U.S.C. 301 (as in effect on December 1, 2013) provided to persons displaced by projects which acquire real property.
Grants, scholarships, fellowships, and gifts used to pay tuition, fees and other necessary educational expenses, in accordance with section 1613(A)(15) of the Social Security Act (as in effect on March 1, 2014) are excluded for nine months.

Funds received from the "Ricky Ray Hemophilia Relief Fund" under the Ricky Ray Hemophilia Relief Fund Act of 1998, Pub. L. No. 105-369 (as in effect on December 1, 2013).

Administrative agency responsibilities. The administrative agency shall:

(1) Consider interest received on excluded funds listed in paragraph (C) of this rule, banked with a financial institution, as a resource unless otherwise specified.

(2) Consider any resource purchased with funds listed in paragraph (C) of this rule as not automatically excluded and subject to medicaid resource requirements.

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(A) This rule describes the exclusion of property no longer the principal place of residence.

(B) A home that is no longer the principal place of residence may continue to remain excluded as a resource for the duration that the property satisfies the provisions governing the treatment of property essential for self-support as found in rule 5160:1-3-05.19 of the Administrative Code.

(C) If a home is no longer the principal place of residence and it does not qualify as property essential for self-support under rule 5160:1-3-05.19 of the Administrative Code, it may remain exempt as a resource if the following requirements are met:

1. The individual must list the property for sale once the property no longer qualifies as either the principal place of residence or as property essential for self-support under rule 5160:1-3-05.19 of the Administrative Code.

2. The individual must provide verification that the property was listed for sale with a real estate agent or real estate firm on or before the date that the property ceased to qualify as either the principal place of residence or as property essential for self-support under rule 5160:1-3-05.19 of the Administrative Code.

3. The property must be listed for sale at an amount not greater than the market value as determined by the county auditor. The administrative agency shall verify the market value by using the assessed value as set by the local county auditor.

4. The individual may not refuse a purchase offer that is equal to or greater than ninety percent of the market value as determined by the county auditor.

5. The proceeds from the sale of the property must be used for the care and support of the Medicaid recipient.

   a. The net proceeds of the property are treated as a lump sum in accordance with rule 5160:1-3-05.8 of the Administrative Code.

   b. The administrative agency must complete a redetermination of continuing eligibility once the property is sold.

   c. The administrative agency shall also apply the provisions of rule 5160:1-3-05.1 of the Administrative Code to determine the proper treatment of shared property.

(D) If the property is not sold within six months after its initial listing as required by paragraph (C) of this rule, the total equity value of the property will be counted as a resource, unless the individual demonstrates that it qualifies as property that has not been sold as set forth in rule 5160:1-3-05.1 of the Administrative Code.

Replaces: 5160:1-3-31.3

Effective: 10/02/2014

Five Year Review (FYR) Dates: 10/02/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 09/22/2014

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02

MEMTL 88

Effective Date: November 2, 2014

(A) This rule describes the application of the home replacement exclusion for purposes of determining eligibility for medical assistance. If the home is being replaced due to loss or damage resulting from a disaster, refer to rule 5160:1-3-05.14 of the Administrative Code.

(B) Definitions.

(1) "Proceeds" mean the net payments received by the seller after satisfaction of all encumbrances and sale expenses.

(2) "Sale expenses" mean all expenses that must be paid by the seller in connection with the sale of the home, including but not limited to broker fees, commissions, legal fees, mortgage-related fees such as points paid by the seller, inspection and settlement fees, and transfer and other accrued taxes paid by the seller.

(C) The home replacement exclusion allows an individual to sell an excluded home that was the individual's principal place of residence without having the proceeds of the sale count as resources if used for the purchase of another excluded home and for the costs incidental to occupying the substitute home.

(1) This exclusion from resources applies to the proceeds of the sale of the excluded home if they are used or obligated to purchase and occupy a substitute excluded home by the last day of the third full month following the month of receipt.

(2) If the home is not replaced within this period, then the proceeds are to be counted as a resource beginning with the month following the month they were received by the individual.

(3) The exclusion does not apply to interest earned on the proceeds of the sale.

(4) The administrative agency shall not implement the exclusion until the statement described in paragraph (E) of this rule is obtained.

(D) The home replacement period begins on the date that the proceeds of the sale are received by the individual. The home replacement period ends on the last day of the third full month following the month the proceeds are received.

(E) If the individual states that the home is being replaced, the administrative agency shall obtain a signed statement from the individual containing the following required information:

(1) Date and amount of proceeds received from the sale of the home; and

(2) The individual's intent of replacing the home with another home by a specific date that represents the last day of the third full month following the month of receipt of the proceeds; and

(3) An acknowledgement that any proceeds of the sale not used for a substitute home by the date in (E)(2) may count in determining eligibility for medical assistance beginning on a specific date that represents the first day of the first month following receipt.

(F) The administrative agency shall verify the amount of the proceeds and the date they were received by obtaining a copy of the settlement sheet or other documents prepared at settlement and received by the individual from the sale.

(G) By the last day of the month in which the home replacement period expires, the administrative agency shall contact the individual to verify the dates and amounts of any allowable costs or deductions for the replacement home by obtaining written evidence (e.g., contracts, bills, receipts, settlement sheets) on the substitute home.

(1) The administrative agency shall charge any retained proceeds not used or contracted to be used toward the replacement home before expiration of the replacement period as a resource beginning with the month following the month of receipt.
(2) If the individual has not replaced the home as intended, all of the proceeds will also count as a resource beginning with the month following the month of receipt.

Replaces: 5160:1-3-31.4
Effective: 11/02/2014
Five Year Review (FYE) Dates: 11/02/2019
Certification: CERTIFIED ELECTRONICALLY
Date: 10/23/2014
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 12/22/86, 11/7/02
This rule describes life estates and life leases as resources.

**Definitions.**

1. "Date of signature" is the date that the individual authorized to transfer the property actually signed the deed or transfer instrument.
2. "Life estate" means an ownership interest in property wherein one person holds the right to possess, use, and obtain profits from the property as long as he or she lives, while another person holds the actual ownership interest in the property.
   - (a) A life estate is a form of legal ownership.
   - (b) It is usually created through an instrument such as deed or will or by operation of law.
   - (c) A life estate instrument often identifies remaindersmen who will take possession of the property upon the expiration of the life estate.
   - (d) A life estate owner owns the property only for the duration of the life estate. The owner can sell only his or her interest in the life estate. The owner cannot take any action concerning the interest of the remaindersman.
3. "Life lease" means a written tenancy agreement giving a person certain rights to property during the person's lifetime.
4. "Look-back period" is defined in rule 5160:1-3-07.2 of the Administrative Code.
5. "Recording date" means the date that the deed is recorded with the county auditor, county recorder, or other appropriate government agency charged with the responsibility for recording real estate transfers and titles.
6. A "remaindersman" has an ownership interest in the physical property but normally does not have the right to possess and use the property until termination of the life estate.

**General description of life estates.**

1. Unless the instrument establishing the life estate places restrictions on the rights of the life estate owner, the owner has the right to possess, use, and obtain profits from the property and to sell his or her life estate interest.
2. Unless restricted by the instrument establishing the remainder interest, the remaindersman is generally free to sell his/her interest in the physical property even before the life estate interest expires.

**Categories of life estates.**

1. Life estates established with the individual's property within the look-back period.
   - (a) A life estate held by an individual falls within this category if it is established with property that the individual held an ownership interest in, and it was established within the applicable look-back period.
   - (b) If the individual has the right to transfer or sell the life estate, it is considered a countable resource unless it qualifies as an excluded resource as described in rule 5160:1-3-05.14 of the Administrative Code.
   - (c) If the individual does not have the right to sell the life estate, the value of the life estate is presumed improperly transferred.
   - (d) The administrative agency must examine the transferred remainder interest under the rules governing the transfer of assets.
(2) Life estates established with the individual's property prior to the look-back period.
   (a) A life estate held by an individual falls within this category if it is established with property
       that the individual held an ownership interest in, and it was established prior to the
       applicable look-back period.
   (b) If the individual has the right to transfer or sell the life estate, it is considered a countable
       resource unless it qualifies as an excluded resource as described in rule 5160:1-3-05.14
       of the Administrative Code.
   (c) A life estate that cannot be sold and was established prior to the look-back period must
       not be considered an improper transfer.
   (d) A remainder interest established prior to the look-back period must not be considered an
       improper transfer.

(3) Life estates not established by the individual.
   (a) A life estate held by an individual falls within this category if it is established with property
       that the individual did not hold an ownership interest in at the time of the establishment of
       the life estate.
   (b) If the individual has the right to transfer or sell the life estate, it is considered a countable
       resource unless it qualifies as an excluded resource.

(E) Effective date of the creation of a life estate.
   (1) For life estates that are recorded within six months after the date of signature, the date of
       signature is the date of transfer.
   (2) If a life estate is recorded more than six months after the date of signature, the individual must
       produce documentation from other sources verifying that the transfer occurred on the date of
       signature rather than the date of recording.
       (a) Such documentation may consist of financial records from lending institutions, tax
           records from governmental agencies, or records from other agencies or private or public
           institutions.
       (b) The individual may provide statements of persons holding a remainder interest, or other
           persons who participated in the creation of the life estate.

(F) Calculating the value of a life estate.
   (1) The administrative agency must first determine the value of the property as established by the
       county auditor. If a valuation by a county auditor is unavailable, the value shall be based upon a
       valuation by the appropriate governmental agency charged with the responsibility for valuation
       of real property.
   (2) The administrative agency must deduct from the value of the property all liens and
       encumbrances that have been placed against the property.
   (3) The administrative agency must deduct from the value of the property all liens and
       encumbrances that have been placed against the life estate.
   (4) After the deductions, the balance is the equity value of the property.
   (5) The administrative agency must multiply the equity value of the property by the product that
       corresponds to the life estate owner's age at the time of determination for medical assistance on
       the following life estate table:

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If the individual disagrees with the county auditor’s determination of the value of the property as described in paragraph (F)(1) of this rule, the individual may have a licensed real estate broker perform an appraisal of the property’s value, which may be substituted as the current value of the property in paragraph (F)(1) of this rule. Such appraisal services may be provided through the use of administrative funds if the individual is unable to obtain an appraisal due to insufficient funds of his or her own.

If the individual transfers or sells a life estate, the individual must receive fair market value for the life estate.

1. The fair market value for the life estate shall be calculated in accordance with paragraph (F) of this rule.

2. If the individual receives less than fair market value for a transferred life estate, the transfer must be examined under the rule governing the transfer of assets.
With respect to a transfer of assets, as referenced in rule 5160:1-3-07.2 of the Administrative Code, the purchase of a life estate interest in another individual's home is a countable resource unless the purchaser resides in the home for a period of at least one year after the date of purchase.

If a life lease is not excluded as the principal place of residence, it must be evaluated as a countable resource. The current market value of a life lease will vary according to the terms agreed upon and the life expectancy of the lessee.

Administrative agency responsibilities. The administrative agency shall:

1. Review the life estate instrument to determine the rights, responsibilities, and/or restrictions placed on the life estate owner and/or the remainderman for new applications for long term care facility (LTCF) services, home and community-based services (HCBS) and program of all inclusive care for the elderly (PACE) services.

2. Determine the effective date of the creation of a life estate.

3. Accept the statements of persons holding a remainder interest, or other persons who participated in the creation of the life estate, only upon a finding that their statements are corroborated and credible.

4. Use the date of recording as the effective date of the creation of the life estate if the individual fails to produce documentation verifying that the transfer occurred on the date of signature.

5. If the life estate has not been recorded, the administrative agency shall request that the individual verify transfer by recording the life estate and, unless the life estate was created within the prior six months, provide documentation as required in paragraph (E)(2) of this rule. If the individual does not provide documentation that the life estate has been recorded, disregard the life estate and consider the entire property as an available resource to the individual.

Replaces: 5160:1-3-32
Effective: 11/02/2014
Five Year Review (FYR) Dates: 11/02/2019
Certification: CERTIFIED ELECTRONICALLY
Date: 10/23/2014
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
This rule describes exclusions when real or personal property is essential to an individual's means of self-support.

**Definition.**

1. "Basic daily living needs", for the purpose of this rule, means any food, basic clothing, basic shelter, and any medical care that are not provided by Medicaid. Items for entertainment or leisure are not basic daily living needs.

2. "Maximum allowable equity" means an individual's equity in income-producing property, up to a maximum of six thousand dollars.

**Categories of property essential to self-support.**

1. Property used in a trade or business, government permits that represent authority granted by a government agency to engage in an income-producing activity, or property used by an individual as an employee for work.
   - Is excluded as a resource regardless of value or rate of return.
   - Government permits includes any permit, license, or similar instrument issued by a federal, state, or local government agency.
   - Personal property used by an employee for work include farm machinery, tools, safety equipment, uniforms, etc.

2. Nonbusiness real or personal property used to produce goods or services essential to basic daily living needs.
   - Up to six thousand dollars of the equity value is excluded, regardless of rate of return.
   - Any portion of the property's equity value in excess of six thousand dollars is a countable resource.
   - Nonbusiness property used to produce goods or services include growing produce or livestock solely for personal consumption in the individual's household or perform activities essential to the production of food solely for home consumption.

3. Nonbusiness income-producing property.
   - Up to six thousand dollars of the equity value is excluded as a resource if the property produces a net annual return equal to at least six per cent of the excluded equity.
   - Any portion of the property's equity value in excess of six thousand dollars is a countable resource.
   - If the property produces less than a six per cent return, the exclusion can only apply if the lower return is for reasons beyond the individual's control and there is a reasonable expectation that the property will again produce a six per cent return. Otherwise, none of the equity value is excluded under this section.
   - If the earnings decline was for reasons beyond the individual's control, up to twenty-four months can be allowed for the property to resume producing a six per cent return. The twenty-four month period begins with the first day of the tax year following the one in which the return dropped to below six per cent.
   - If the tax return shows that the activity has operated at a loss for the two most recent years or longer, the property cannot be excluded unless the individual submits current receipts and records to show that it currently is producing a six per cent return.
(f) If an individual owns more than one piece of income-producing property, the six per cent return requirement applies individually to each property and the six thousand dollar equity value limit applies to the total equity value of all the properties meeting the six per cent return requirement.

(g) If all properties meet the six per cent test but the total equity value exceeds six thousand dollars, that portion of the total equity value in excess of six thousand dollars is a countable resource.

(D) For any of the exclusions to apply, the property must be in current use.

(E) Property not in current use. If the property is not in current use, it must be for reasons beyond the individual's control and there must be a reasonable expectation that the use will resume within twelve months of last use.

(1) If an individual alleges that self-support property is not in current use because of a disabling condition of the individual, the individual must provide a treating physician's, advanced practice registered nurse's (APRN), or physician assistant's (PA) signed statement describing the nature of the condition, the date the individual ceased the self-support activity, and the date the physician, APRN, or PA will allow the individual to resume the activity, if at all.

(2) If the individual does not intend to resume the self-support activity, the property is a countable resource in the month after the month of last use.

(3) If, after property has been excluded because an individual intends to resume self-support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. The property is a resource in the following month.

(F) Individual responsibilities. The individual shall:

(1) Provide a copy of the tax return for the tax year prior to application or reapplication to be used to determine the net income earned for the individual from the income-producing property.

(2) Provide pertinent documents and a signed statement if the individual alleges owning a government license, permit, or other property that represents government authority to engage in an income-producing activity, and has value as a resource. The statement shall include:

(a) The type of license, permit or other property;
(b) The name of the issuing agency, if appropriate;
(c) Whether the law requires such license, permit, or property for engaging in the income-producing activity at issue; and
(d) How the license, permit, or other property is being used; or
(e) Why it is not being used.

(3) Provide a statement if the individual alleges owning items used in his or her work as an employee. The statement shall include:

(a) The name, address, and telephone number of the employer;
(b) A general description of the items;
(c) A general description of the individual's duties; and
(d) Whether the items are currently being used.

(G) Administrative agency responsibilities. The administrative agency shall:

(1) Determine whether the property qualifies under one of the three categories identified in paragraph (C) of this rule if the individual asserts his or her property is essential for self-support.

(2) Determine whether to exclude equity in nonbusiness income-producing property described in paragraph (C)(3) of this rule as follows:
Determine the individual's maximum allowable equity in the property.

Multiple the individual's maximum allowable equity by six per cent.

Establish the net annual income the property produces for the individual.

(i) If the income to the individual is equal to or greater than the six per cent calculated in paragraph (G)(2)(b) of this rule, then the maximum allowable equity is not counted as a resource.

(ii) If the income to the individual is less than the six per cent calculated in paragraph (K)(G)(b) of this rule, then the individual's entire equity is counted as an available resource.

If there is more than one potentially excluded property, the six per cent return requirement applies individually to each property and the six thousand dollars equity value limit applies to the total equity value of all the properties meeting the six per cent return requirement.

Determine whether to exclude equity in property that provides either a product or a service that supplies basic daily living needs for the individual.

(a) If the property does provide basic daily living needs for the individual, then the individual's equity up to a maximum of six thousand dollars shall not be counted as a resource. Any equity in excess of six thousand dollars shall be counted as a resource.

(b) If the property does not provide basic daily living needs for the individual, then the entire equity is a countable resource.

Apply only the provision that is most beneficial to the individual if the individual's property falls under more than one of the categories in paragraph (C) of this rule.

Request any other documentation necessary to fully and adequately distinguish between the income from the income-producing property, and income from other sources.

Consider the individual's entire equity as a countable resource if the individual fails to cooperate with providing the appropriate documentation.

Replaces: 5160:1-3-33

Effective: 11/02/2014

Five Year Review (FYR) Dates: 11/02/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 10/23/2014

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02

Prior Effective Dates: 9/3/77, 2/1/79, 10/1/79, 1/3/80, 10/1/95, 11/7/02
This rule describes the deeming of resources from spouse to spouse or parent(s) to a child who are living in the same home when determining eligibility for medical assistance.

Definitions.

1. "Child", for deeming purposes, means an individual under age eighteen who lives in the home with one or both parents and is neither married nor head of household. The deeming of parental resources applies through the month in which the child becomes eighteen years old. An eligible or ineligible child's resources are never deemed to parent(s) or sibling(s).

2. "Eligible child" means a child in the home who has applied for medical assistance for the aged, blind, or disabled, and who meets all the applicable non-financial and financial eligibility criteria.

3. "Eligible spouse" means the member of a married couple who has applied for medical assistance for the aged, blind, or disabled, and who meets all the applicable non-financial and financial eligibility criteria.

4. "Parent" means a natural or adoptive father or mother living in the same home as the eligible child. The resources of a stepparent who lives with the eligible child is deemed to the child only when the natural or adoptive parent also lives in the home with the stepparent and child. If the natural or adoptive parent divorces a stepparent and the child is living with the stepparent, the stepparent is not a parent or spouse for deeming purposes.

5. "Spouse" means a person who is legally married to another under Ohio law.

Only the resources of the individual's spouse or the parent(s) of a child are considered for purposes of deeming resources.

In deeming resources from one spouse to the other, only the resources of those two individuals are considered. In deeming resources from a parent to a child, only the resources of the parent are considered.

Spouse to spouse deeming.

1. When an eligible individual and their spouse live together, all resources are combined and the couple is permitted resources in the amount described in rule 5160:1-3-05.1 of the Administrative Code in addition to what is exempt as described in rule 5160:1-3-05.14 of the Administrative Code. The couple's resource limitation is not affected by whether the spouse of the eligible individual is eligible or ineligible for medical assistance.

Parent to child deeming.

1. The resource limit for a child is described in rule 5160:1-3-05.1 of the Administrative Code in addition to what is excluded as described in rule 5160:1-3-05.14 of the Administrative Code.

2. The resources of a child consist of whatever resources the child has in his or her own right plus whatever resources are deemed to the child from his or her parent(s).

3. In determining the amount of resources to be deemed to an otherwise eligible child, the resources of the child and of the parents are computed separately and both the child and the parents are each allowed all of the resource exclusions they would normally be eligible for in their own right. Only one home and one automobile are excluded.

   a. For purposes of deeming, it does not matter whether the parent(s) is or is not eligible for medical assistance.

   b. After the exclusions are applied, only the countable resources over the resource exclusion of the parent(s) living in the home are deemed to the child when there is only one child.
When there is one parent in the home the parental resource exclusion is one thousand five hundred dollars.

When both parents are in the home the parental resource exclusion is two thousand two hundred fifty dollars.

(c) When there is more than one eligible child, the resources available for deeming are shared equally among the eligible children.

(d) None of the parents’ resources are deemed to any other ineligible children.

(4) A child is not eligible for medical assistance if his or her own countable resources plus the value of the parents’ resources deemed to the child exceed the resource limit for a child described in rule 5160:1-3-05.1 of the Administrative Code.

(G) When the individual is not living in a home with a spouse or parent(s) only the resources of the individual are considered. Such an individual is subject to the resource limit for an individual described in rule 5160:1-3-05.1 of the Administrative Code.

(1) When an eligible individual and spouse are no longer living together, each person is considered as an individual living alone beginning the month after separation. The individual resource limit, as described in rule 5160:1-3-05.1 of the Administrative Code, is then applicable.

(a) For the month of separation, the spouses are treated as an eligible couple or as an eligible individual and ineligible spouse living together in the same household with a resource limit for a couple described in rule 5160:1-3-05.1 of the Administrative Code.

(b) In the month after the month of separation, resources are computed separately because each person is now considered to be an individual without a spouse.

(2) Spouses or parents and children who are separated because of placement in a medical institution have resources considered in accordance with the policy contained in Chapter 5160:1-3 of the Administrative Code.

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MEMTL 88

Effective Date: November 2, 2014

(A) This rule describes the treatment of income and resources for institutionalized individuals when determining eligibility for medical assistance.

(B) Institutionalized individual with no spouse.
   (1) Individuals at least age twenty-one who have no spouse.
   (2) Only the income and resources of the individual and any contributed income and resources are considered in the eligibility and post-eligibility determinations.

(C) Institutionalized children.
   (1) For the month in which a child enters the institution, the child is considered living with the family. The income and resources of the parent(s) is considered available to the child in the month of institutionalization.
   (2) The month following the month of institutionalization, the child is treated as an individual living alone. The child's own income and resources and any contributed income and resources are considered in the eligibility and post-eligibility determinations.

(D) Institutionalized couples.
   (1) Institutionalized couples shall be treated as individuals the month following the month of institutionalization. Only income and resources that are attributable to the individual are applied to the individual. This policy applies to all couples regardless of their living arrangement in the medical institution.
   (2) Couples who enter the medical institution in the same month are treated as a couple the month of entering the facility. The month after the month of entering the medical institution, they are treated as individuals.

(E) Institutionalized individual with a community spouse.
   (1) Spouses separated by a continuous period of institutionalization are considered to be living apart the month the institutionalized spouse (IS) enters the institution. Only the income and resources deemed to the IS and any income and resources actually contributed to the IS are considered available in the IS's financial eligibility and post-eligibility determinations.
   (2) A continuous period of institutionalization is defined as an admission to a medical institution (or receipt of home and community-based waiver services) for a period of at least thirty consecutive days.
   (3) The continuous period of institutionalization may include a combination of institutionalization in a hospital setting and a long term care facility (and/or receipt of home and community-based waiver services).
   (4) Continuity of institutionalization is broken by any absences from the institution for thirty consecutive days or non-receipt of home and community-based waiver services for thirty consecutive days.
   (5) A continuous period of institutionalization is also established when an individual is admitted to a medical institution or begins receiving waiver services under an HCBS waiver and is "likely to remain" or "likely to receive waiver services" for a period of at least thirty consecutive days.
   (a) Individuals are considered likely to remain or likely to receive waiver services, even though they do not actually remain or continue to receive waiver services, when it is determined that the individual is likely to remain or likely to receive waiver services for thirty consecutive days.
For a hospitalized individual, a physician’s, advanced practice registered nurse’s (APRN), or physician assistant’s (PA) statement verifying that the individual is likely to remain at least thirty consecutive days is required.

A continuous period of institutionalization in an LTCF must be certified by a physician’s, APRN’s, or PA’s statement or the completed ODM 03697 "Patient Care And Plan of Treatment (rev. 7/2014). The ODM 03697 must provide sufficient information that institutionalization is reasonably expected to continue for at least thirty consecutive days.

The approval notice of HCBS waiver services shall be used to verify the individual is likely to receive waiver services for a period of at least thirty consecutive days.

A continuous period of institutionalization is also established if the individual dies prior to the thirtieth consecutive day when it is determined that the individual would have likely continued to remain institutionalized or in receipt of HCBS waiver services.

The continuous period of institutionalization may include a combination of institutionalization in a hospital setting and a long term care facility and/or receipt of home and community-based waiver services.

In accordance with rule 5160:1-3-06.3 of the Administrative Code, spousal impoverishment provisions are not implemented until the individual has actually been institutionalized for thirty consecutive days; however, the continuous period begins the date the individual was institutionalized or began receiving HCBS waiver services.

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This rule defines how resources, existing at the beginning of the first continuous period of institutionalization, are identified and assessed for purposes of determining medicaid eligibility.

Definitions.

1. "Continuous period of institutionalization" means an admission to a medical institution, receipt of home and community based waiver services, or receipt of services under a program of all inclusive care for the elderly, for a period of at least thirty consecutive days.

2. "Institutionalized" describes an individual who receives long-term care (LTC) services in a medical institution, a long-term care facility, under a home and community based services (HCBS) waiver program or under program of all inclusive care for the elderly (PACE) for at least thirty consecutive days.

3. "Resource assessment" means the process where the resources of both the institutionalized spouse and the community spouse are assessed to determine the couple’s total countable resources existing at the beginning of the first continuous period of institutionalization.

Documentation of ownership and current value of the couple’s countable resources shall be completed in accordance with Chapter 5160:1-3 of the Administrative Code. The only resource exclusions for the resource assessment and the determination of countable resources at the time of application are:

1. The homestead property.
2. One automobile, regardless of value.
3. Household goods and personal effects.
4. The value of any burial space and/or irrevocable preneed funeral contract (including the interest that accumulates) for the individual, spouse, or any other member of the immediate family.
5. Resources in a plan for achieving self-support (PASS) account.
6. Property that is essential to self-support in accordance with rule 5160:1-3-05.19 of the Administrative Code.
7. Assistance provided pursuant to a federal statute, on account of a catastrophe, which is to be declared a major disaster by the president, for a period of nine months beginning the date the funds are received.
8. Any underpayment of supplemental security income (SSI) or social security benefits is excluded for the first six months following the month of receipt.
9. Assistance paid with respect to the dwelling unit occupied by the individual and/or spouse for subsidized housing.
10. Victim’s assistance payments paid by a fund established by the state to aid victims of crime as compensation, for expenses incurred or losses suffered as a result of a crime for a period of nine months beginning the month after the month in which the payment is received.
11. Relocation assistance provided by the state or local government for a period of nine months beginning the month after the month in which the payment is received.
12. If the total face value of all life insurance policies on any individual is one thousand five hundred dollars or less, the policies are totally excluded from being counted as resources. If the total face value of all policies on an individual exceeds one thousand five hundred dollars, the entire cash surrender value of such policies must be counted as resources. Term and burial insurance policies, for which no cash value accumulates, are not used in determining whether the total value of all policies is over one thousand five hundred dollars.
Administrative agency responsibilities.

(1) A resource assessment shall be completed when one member of a couple is applying for services under an HCBS waiver or PACE. When both members of a couple are applying for services under an HCBS waiver or PACE, a resource assessment is not completed. Individuals who had a resource assessment completed previously due to LTCF placement, or other institutionalization, will not have another resource assessment completed.

(a) When the first continuous period of institutionalization began under a HCBS waiver program or under community based PACE, the date of the first continuous period of institutionalization for resources assessment purposes is the date the individual is authorized by the HCBS waiver agency or PACE agency to receive services.

(b) After the completion of the resource assessment, there shall be no deeming of spousal resources to the individual receiving services under HCBS waiver program or PACE. The individual's countable resources cannot exceed the resource standard of one thousand five hundred dollars for HCBS waiver or PACE.

(2) All individuals entering an LTCF on or after January 1, 1990, who have a spouse in the community, shall be provided with a notice concerning the individual's right to a resource assessment. The LTCF is responsible for ensuring that all individuals receive this notice upon entering the facility.

(3) The purpose of the resource assessment is to aid in the determination of the amount of resources that may be transferred from the institutionalized spouse to the community spouse should an application be filed in conjunction with the request for an assessment of resources or filed at a later date. Additionally, the resource assessment aids in the determination of whether or not resources were recently transferred.

(4) One resource assessment is completed per individual member in a couple when one spouse is institutionalized, returns home and then subsequently the other spouse becomes institutionalized.

(5) If an institutionalized individual marries someone in the community, the resource assessment is based on the date of the marriage.

(6) The administrative agency shall only accept the first period of continuous institutionalization from another state and not the resource assessment. A new resource assessment must be completed when the individual becomes a resident of Ohio and meets the definition of institutionalized as defined in paragraph (B) of this rule.

(7) A resource transferred prior to the individual becoming institutionalized is not included on a resource assessment. A transfer made by either spouse must be evaluated in accordance with Chapter 5160:1-3 of the Administrative Code. If an improper transfer has occurred, a period of restricted coverage must be imposed in accordance with the applicable regulations.

(8) All individuals requesting a resource assessment shall have the assessment completed by the administrative agency within forty-five days of the request (additional time may be allowed if the administrative agency determines it is necessary).

(a) The request may be made by either member of a couple or by an authorized representative of either spouse.

(b) Receipt of a request for a resource assessment from an LTCF, with the individual's or the individual's spouse's signature, indicates the beginning of the forty-five days.

(c) The assessment shall be determined using the couple's countable resources as of the beginning of the first continuous period of institutionalization that occurs on or after January 1, 1990.

(d) Each member of the couple and the authorized representative of either spouse must be provided with a copy of the ODM 04076 "Resource Assessment Worksheet" (rev. 7/2014). A copy must also be retained by the administrative agency.
When a resource assessment is requested that is not in conjunction with a medicaid application, a fee of fifty dollars shall be charged upon request for the resource assessment to the individual requesting the assessment.

(a) A copy of the resource assessment shall be given to the community spouse and the institutionalized spouse and authorized representative, if applicable.

(b) A copy shall also be retained by the administrative agency for a period of up to three years.

(c) The assessment shall be used if the institutionalized spouse applies for medicaid at a later date.

(d) If an institutionalized spouse does not have a resource assessment completed at the time of the first continuous period of institutionalization, and requests one at a later date, the resources of the institutionalized spouse and the community spouse shall be recorded to reflect the circumstances as they were at the beginning of the first continuous period of institutionalization.

(e) There is no right to a state hearing on an assessment not filed in conjunction with a medicaid application. However, should a medicaid application be filed subsequent to the resource assessment, either spouse or the authorized representative of either spouse, may request a state hearing to contest the assessment.

(f) If documentation is not provided timely, the requesting party shall be advised via the appropriate county generated or electronic eligibility system notice that the assessment cannot be completed. Subsequently, if another resource assessment is requested that is not in conjunction with a medicaid application, a fee of fifty dollars shall be charged. Any documentation collected by the administrative agency shall be retained by the administrative agency.

When a resource assessment is requested in conjunction with a medicaid application, there is no fee for the assessment. Additionally, either spouse or the authorized representative may request a state hearing regarding the resource assessment.

All resources determined available at the beginning of the first continuous period of institutionalization shall be used in the resource assessment. Resources transferred prior to the first continuous period of institutionalization shall not be used to complete the resource assessment. Resources transferred after the first continuous period of institutionalization shall be used in the resource assessment because they would have been available at the point of the first period of institutionalization. The administrative agency shall determine improper resource transfers and the periods of ineligibility or restricted coverage in accordance with Chapter 5160:1-3 of the Administrative Code.

Antenuptial agreements, prenuptial agreements, and any other similar agreements or contracts entered into in contemplation or marriage shall be disregarded when conducting a resource assessment.

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This rule describes the treatment of resources owned by institutionalized individuals with a community spouse.

Definitions.

(1) "Community spouse" means an individual who is not in a medical institution or nursing facility and has an institutionalized spouse; however, when both spouses are requesting or receiving services under a home and community based services (HCBS) waiver program or program of all inclusive care for the elderly (PACE), neither spouse is considered to meet this definition.

(2) "Institutionalized spouse" means an individual who receives long-term care services in a medical institution, a long-term facility, under a HCBS waiver program, or under PACE for at least thirty consecutive days.

(3) "Spousal resource maximum" means the maximum amount of a couple's countable resources allowed for use by the community spouse.

(4) "Spousal resource minimum" means the minimum amount of a couple's countable resources allowed for use by the community spouse.

If the institutionalized spouse applies for medical assistance at any time, the amount of resources that were allocated to the community spouse as a result of the resource assessment is used to determine the amount of current resources that is allocated to the institutionalized spouse and community spouse.

(1) A resource assessment is completed based upon the beginning of the first continuous period of institutionalization, not the date(s) of application for medical assistance.

(2) Only one resource assessment is completed per couple regardless of how often an individual has been institutionalized or has applied for medical assistance.

(3) At the time of application for medical assistance a determination of the institutionalized spouse’s and community spouse's current combined resources is computed. The community spouse is entitled to the amount of resources that were allocated to the community spouse by the resource assessment.

The calculation used to determine the amount of resources that can be transferred includes two key terms: the spousal resource minimum and the spousal resource maximum. The spousal resource minimum and spousal resource maximum are described in section 1924 of the Social Security Act (as in effect on February 1, 2014) and are adjusted annually.

The budgeting methodology used to determine the institutionalized spouse's resource eligibility is outlined in rule 5160:1-3-06.4 of the Administrative Code.

Administrative agency responsibilities. The administrative agency shall:

(1) Determine the amount of resources that may be transferred from the institutionalized spouse to the community spouse, in order to:

   (a) Determine if the institutionalized spouse is resource eligible; and

   (b) Protect a portion of the resources for the use of the community spouse.

(2) Give the institutionalized spouse a period of protected eligibility, in accordance with rule 5160:1-3-06.5 of the Administrative Code, to give the couple time to complete any necessary resource transfers once eligibility is established.
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MEMTL 88

Effective Date: November 2, 2014

(A) This rule outlines the resource budgeting methodology used to:

(1) Determine the amount of resources that may be transferred from the institutionalized spouse to the community spouse; and

(2) Protect a portion of the combined countable resources for the community spouse.

(B) Definitions.

(1) "Community spouse" is defined in rule 5160:1-3-06.3 of the Administrative Code.

(2) "Institutionalized spouse" is defined in rule 5160:1-3-06.3 of the Administrative Code.

(3) "Spousal resource maximum" is defined in rule 5160:1-3-06.3 of the Administrative Code.

(4) "Spousal resource minimum" is defined in rule 5160:1-3-06.3 of the Administrative Code.

(5) "Undue hardship" is defined in rule 5160:1-3-07.2 of the Administrative Code.

(C) The ODM 04077 "Resource Transfer Worksheet" (rev. 7/2014) shall be used to calculate the amount of resources that may be transferred from the institutionalized spouse to the community spouse.

(1) Determine the spousal share of the resources by dividing the total countable resources established the date of the first continuous period of institutionalization on the ODM 04076 "Resource Assessment Worksheet" (rev. 7/2014) by two.

(2) Determine the couple's current combined countable resources as of the date of application for medical assistance. This may differ from the amount established by the ODM 04076 (depending on whether the assessment was completed concurrently with the application for long-term care medical assistance).

(3) The community spouse resource allowance is the greatest of the following:

(a) The community spousal share or the community spousal resource maximum (in accordance with rule 5160:1-3-6.3 of the Administrative Code) whichever is less; or

(b) The spousal resource minimum (in accordance with rule 5160:1-3-6.3 of the Administrative Code); or

(c) The allocation of resources specified in a current court order or by a state hearing decision.

(4) Deduct the community spouse resource allowance (the amount determined in paragraph (C)(3) of this rule) from the couple's current combined countable resources. The remaining amount is the countable resources of the institutionalized spouse and is to be used only for the benefit of the institutionalized spouse and/or community spouse.

(a) If this remaining amount is equal to or less than the resource limit for one, (pursuant to Chapter 5160:1-3-05.1 of the Administrative Code), resource eligibility potentially exists and the transfer of resource provisions specified in Chapter 5160:1-3 of the Administrative Code are followed.

(i) To determine the amount of resources that must be transferred to the community spouse, deduct the individual medicaid resource limit from the amount of resources in the institutionalized spouse's name only and/or held jointly by both spouses.

(ii) The institutionalized spouse may then transfer up to the amount of the community spouse's resource allowance less the amount that is solely in the name of the community spouse.
(iii) The remaining assets are considered available to the institutionalized spouse.

(iv) These remaining resources must only be used for the benefit of the institutionalized spouse and/or community spouse.

(b) If the remaining amount is over the resource limit for one, resource eligibility does not exist at this time. The ODM 07332 "Notice of Denial of Your Application for Medicaid: In Cases Involving Community Spouses" (rev. 7/2014) or the appropriate electronic eligibility system notice must be issued.

(i) Resource eligibility will exist when the combined countable resources of the couple are reduced to the greatest of the following:

(a) The community spouse resource allowance plus individual resource limit for one; or

(b) The allocation of resources described in paragraph (C)(3)(c) of this rule (subsequent to the medicaid denial) plus the individual resource limit for one.

(ii) Resource eligibility will otherwise exist if the administrative agency determines that undue hardship exists. Reference rule 5160:1-3-07.2 of the Administrative Code for a determination of when an undue hardship exists.

(5) The resource budgeting computation can be revised if the administrative agency determines inaccurate information was provided or an error was made at any step in the resource budgeting computation.

(6) The community spouse resource allowance may be increased by an amount sufficient to generate additional income to the community spouse, if both of the following conditions are met:

(a) All available income of the institutionalized spouse has been allocated to the community spouse and the income of the institutionalized spouse is not adequate to raise the income of the community spouse to the established minimum monthly maintenance needs allowance; and

(b) A state hearing decision, in accordance with rule 5101:6-7-02 of the Administrative Code, has determined the original community spouse resource allowance, in relation to the amount of income it generates, is not adequate to raise the income of the community spouse to the established minimum monthly maintenance needs allowance.

(D) When the institutionalized spouse is determined to have resources in excess of the individual resource limit, the institutionalized individual is ineligible for medical assistance due to excess resources; however, the institutionalized spouse must be found eligible for medical assistance if all of the following conditions exist:

(1) The institutionalized spouse's own resources are at or below the individual resource limit; and

(2) The community spouse will not cooperate in making resources available to the institutionalized spouse after a resource assessment has been completed; and

(3) The institutionalized spouse, or other person standing in place of the institutionalized spouse, has assigned his or her rights to support from the community spouse to the state. If the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment, the state will bring a support proceeding against the community spouse as provided for in sections 5160.37 and 5160.38 of the Revised Code; and

(4) All other medicaid eligibility requirements have been met.

(E) Prior to the final decision to approve or deny medical assistance, the community spouse must be given notice of the responsibility to cooperate in making resources available to the institutionalized spouse and legal action may be taken against the community spouse for refusing to do so. If the community spouse refuses to cooperate, medical assistance must be approved, provided that all other eligibility factors and the conditions stated in paragraph (D) of this rule have been met. The administrative
agency must refer the case to the state attorney general's office, who must attempt to recover funds from the community spouse for any medical payments paid by medicaid up to the institutionalized spouse's allocated share of the couple's assets. However, recovery cannot reduce the remaining resources of the community spouse below the community spouse resource allowance. That amount remains protected for the community spouse. Section 5160.37 of the Revised Code authorizes the administrative agency to pursue recovery of medicaid payments made on behalf of the institutionalized spouse.

1. When it is determined an institutionalized spouse has resources in excess of the individual resource limit due to resources in the name of the community spouse, the administrative agency must send a notice to the community spouse and a copy sent to the institutionalized spouse advising the community spouse of the amount of resources that must be made available to the institutionalized spouse. A copy of the completed ODM 04076 and a copy of the ODM 04077 must accompany the notice. The community spouse must complete and return the notice within ten calendar days of the mailing date.

2. If the community spouse returns the notice within ten calendar days of the mailing date with the block checked indicating the community spouse will cooperate, the administrative agency must deny the application due to excess resources of the institutionalized spouse.

3. If the community spouse fails to return the notice or returns the notice indicating that he or she will not cooperate and the institutionalized spouse meets the requirements of paragraph (D) of this rule, the administrative agency must take the following actions:
   a. Medical assistance for the institutionalized spouse must be approved; and
   b. The ODM 07403 "Community Spouse Resource and Income Information Form" (rev. 7/2014) must be completed. This notice must be completed as soon as possible after the ten calendar days have passed. The administrative agency must attempt to document all pertinent information regarding the resources and income of the community spouse on this form. A copy of the ODM 07403 must be retained in the individual's record. The original ODM 07403 and copies of all pertinent documentation must be sent to the collections enforcement section of the office of the attorney general.
   c. If all other eligibility requirements are met, the institutionalized spouse must remain eligible for medical assistance while legal action proceeds.

4. The administrative agency must apply the provisions set forth in this rule to institutionalized applicants who exceed the resource limit solely due to resources of the community spouse.

F. In unusual circumstances a resource assessment cannot be completed due to the non-cooperation of the community spouse.

1. When the community spouse refuses or fails to cooperate, the institutionalized spouse or other person standing in place of the institutionalized spouse must assign rights to support from the community spouse to the state.

2. If all other eligibility factors have been met, and the institutionalized spouse is cooperating in obtaining the necessary verifications from his or her spouse, the administrative agency must approve the institutionalized spouse for medical assistance until the verifications are obtained.

3. Undue hardship does not exist when the institutionalized spouse has transferred assets to the community spouse and the community spouse refuses to cooperate in completing a resource assessment or making the resources available to the institutionalized spouse.
5160:1-3-06.5 Medicaid: Transfer of Resources for Institutionalized Spouses with a Spouse in the Community

**MEMTL 88**

**Effective Date: November 2, 2014**

(A) This rule describes the transfer of resources for institutionalized spouses with a spouse in the community.

(B) Once eligibility has been established, resources not used to determine eligibility for an institutionalized spouse, in accordance with rule 5160:1-3-6.4 of the Administrative Code, must be legally transferred to the community spouse when not already in the name of such person.

1. The institutionalized spouse is entitled to a period of protected eligibility while the resources are being transferred legally to the community spouse.

2. The period of protected eligibility is twelve months or one year from the month in which the eligibility determination is completed.

3. The resource transfer must take place no later than the twelfth month after the month of the eligibility determination and authorization.

4. Resources being transferred do not count for the purpose of determining continuing eligibility for the institutionalized spouse.

(C) If the institutionalized spouse comes into additional resources, during a period of protected eligibility, those resources will be exempt when at least one of the following conditions exist:

1. The new resources combined with other resources the institutionalized spouse intends to retain, do not exceed the resource limit for one person; and/or

2. The institutionalized spouse intends to transfer the new resources to the community spouse whose resources are below what have been protected through the resource assessment. If the original amount of protected resources for the community spouse was less than the spousal resource allowance, the institutionalized spouse may transfer to the community spouse the amount which will bring the community spouse’s resources up to the determined spousal resource allowance.

(D) If the institutionalized spouse fails to transfer resources to the community spouse within the protected period of eligibility, eligibility for the institutionalized spouse shall be determined counting all of the resources in the institutionalized spouse’s name.

(E) Eligibility requirements for community spouses and other family members do not change when it is determined that a transfer of resources from the institutionalized spouse to the community spouse has occurred.

1. Resources are considered in accordance with the rules in Chapter 5160:1-3 of the Administrative Code that would apply to each individual.

2. Those resources that the institutionalized spouse intends to transfer to the community spouse are considered to be available to the community spouse during the institutionalized spouse’s protected eligibility period.

(F) Administrative agency responsibilities. The administrative agency shall:

1. Determine if additional resources received by the institutionalized spouse, during the protected period of eligibility, can be transferred to the community spouse.

2. Take the appropriate actions necessary if the institutionalized spouse has resources which exceed the individual resource standard.

3. Determine resource eligibility for each month of the retroactive period in accordance with rule 5160:1-1-51 of the Administrative Code. Deduct from the current countable resources the community spouse resource allowance for each month of the retroactive period.
(a) This method of determining resource eligibility is used since there is no protected period of medicaid eligibility to transfer resources to a community spouse because the couple was unaware that such transfers may be allowed to ensure eligibility for the institutionalized spouse.

(b) This does not apply for retroactive periods associated with subsequent applications for the same period of institutionalization.

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This rule defines the treatment of a transfer of resources.

(A) Definitions.

(1) "Administrative agency" means the county department of job and family services, the Ohio department of job and family services, or other entity that determines eligibility for a medical assistance program.

(2) "Assets" are defined in rule 5101:1-39-05 of the Administrative Code.

(3) The "baseline date" means the first date upon which the individual has both applied for medicaid and is institutionalized.

(a) When an individual is already a medicaid recipient and becomes institutionalized, the baseline date is the first day of institutionalization.

(b) The baseline date for individuals already in receipt of medicaid and applying for a home and community-based services waiver (HCBS) is the signature date on the JFS 02399 "Request for Home and Community-based Services (HCBS)" (rev. 1/2006), if the administrative agency receives the signed and dated form within five working days from the date of the signature on the JFS 02399. If the administrative agency receives the JFS 02399 after the fifth working day, the baseline date shall be the date the administrative agency received the JFS 02399.

(c) The baseline date for individuals not in receipt of medicaid, who are applying for HCBS, is the signature on the JFS 02399 if both of the following conditions are met:

(i) A signed and dated JFS 02399 is received within five working days from the date of the signature on the JFS 02399; and

(ii) A signed and dated JFS 07200 "Request for Cash, Food Stamp, and Medical Assistance" (rev. 10/2006) is received within thirty calendar days from the signature date on the JFS 02399.

(d) The baseline date for individuals, who are not in receipt of medicaid and are applying for the program of all inclusive care for the elderly (PACE), is the signature date on the JFS 02398 (rev. 8/1999) "Program of All Inclusive Care for the Elderly (PACE) Referral" if both of the following conditions are met:

(i) A signed and dated JFS 02398 is received within five working days from the date of the signature on the JFS 02398; and

(ii) A signed and dated JFS 07200 is received within thirty calendar days from the signature date on the JFS 02399.

(4) "Fair market value" is defined in rule 5101:1-39-05 of the Administrative Code.

(5) An "improper transfer" means a transfer on or any time after the look-back date, as defined in paragraph (B)(9) of this rule, of a legal or equitable interest in a resource for less than fair market value for the purpose of qualifying for medicaid, a greater amount of medicaid, or for the purpose of avoiding the utilization of the resource to meet medical needs or other living expenses.

(6) "Income" is defined in rule 5101:1-39-08 of the Administrative Code.
"Individual," as used in this rule, includes the applicant/recipient of a medical assistance program, as well as:

(a) The applicant/recipient's spouse;

(b) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; and

(c) Any person, including a court or administrative body, acting at the direction or upon request of the individual or the individual's spouse.

"Long term care facility (LTCF)" means a medicaid-certified nursing facility, skilled nursing facility, or intermediate care facility for persons with mental retardation as defined in division 5101:3 of the Administrative Code.

The "look-back date" means the earliest date on which a penalty for transferring assets for less than fair market value can be assessed. The look-back date is sixty months prior to the baseline date.

(a) When an individual has multiple periods of institutionalization or has made multiple applications for medicaid, whether the applications were approved or denied, the look-back date is based on the first date upon which the individual has both applied for medicaid and is institutionalized.

(b) Each individual has only one look-back date regardless of the number of times the individual has been institutionalized, applied for medicaid, transferred assets, or been eligible for medicaid.

The "look-back period" begins with the baseline date and ends with the look-back date.

(a) Transfers during the look-back period must be examined to determine whether the transfer was improper and subject to a restricted medicaid coverage period.

(b) Improper transfers that occur prior to February 8, 2006 and during the look-back period are subject to a restricted medicaid coverage period if either of the following conditions exist:

(i) The improper transfer, other than a transfer of a trust, was made within thirty-six months prior to the baseline date; or

(ii) The improper transfer of a trust was made within sixty months prior to the baseline date. The treatment of a trust is defined in rule 5101:1-39-27.1 of the Administrative Code.

(c) Improper transfers that occur on or after February 8, 2006 and during the look-back period are subject to a restricted medicaid coverage period.

(d) Transfers after the baseline date must be examined to determine if they are improper and subject to a restricted medicaid coverage period.

"Resources" are defined in rule 5101:1-39-05 of the Administrative Code.

"Restricted medicaid coverage" means the period of time an individual is ineligible for nursing facility payments, a level of care in any institution equivalent to that of nursing facility services and home or community-based services furnished under a waiver and PACE.

A "spouse" means a person who is considered legally married to another under Ohio law.

A "transfer" means any action or failure to act which has the effect of changing an ownership interest of an asset from the individual to another person, or of preventing an ownership interest the individual would otherwise have enjoyed. This includes any direct or indirect method of disposing of an interest in property.

The following types of transfers are presumed to be improper transfers for less than fair market value:
(1) Any transfer that reduces the individual's resources and brings the value of their remaining resources within the resource limitation;

(2) Any transfer that has the effect of safeguarding future eligibility by divesting the individual of property that could otherwise be sold and the proceeds then used to pay for support and medical care for the individual;

(3) Any transfer of income-producing real property; or

(4) Any transfer by an individual of an exempt home as defined in Chapter 5101:1-39 of the Administrative Code, whether prior to or after the medicaid application date.

(5) For an asset to be considered transferred for fair market value or to be considered to be transferred for valuable consideration, the consideration received for the asset must have a monetary value.

(6) A transfer for love and consideration is not considered a transfer for fair market value. Clear and convincing evidence is required to rebut the presumption that it is an improper transfer.

(D) Rebutting the presumption of an improper transfer.

(1) The individual may rebut the presumption established under paragraph (C) of this rule. The individual must first provide a full written accounting and documentation of the transfer which clearly explains the following:

   (a) The purpose for transferring the resource; and
   (b) The attempts to dispose of the resource at fair market value; and
   (c) The reasons for accepting less than fair market value for the resource; and
   (d) The individual's relationship, if any, to the person to whom the resource was transferred.

(2) The individual has the burden of rebutting the presumption of improper transfer by clear, convincing, and credible evidence.

   (a) The evidence may include, but is not limited to: any documentary evidence such as contracts, realtor agreements, sworn statements, third party statements, medical records, financial records, court records, and relevant correspondence.
   (b) Evidence which is provided must be reviewed by the administrative agency to determine if it is clear, convincing and credible.
   (c) Evidence that is not clear, convincing and credible does not rebut the presumption of an improper transfer.

(3) The occurrence after a transfer of the resources of one or more of the following, while not conclusive, may indicate resources were transferred exclusively for some purpose other than establishing medicaid eligibility:

   (a) Traumatic onset of disability or blindness (e.g., due to traffic accident); or
   (b) Diagnosis of a previously undetected disabling condition.

(4) If the presumption of improper transfer is not overcome by the individual's rebuttal, the administrative agency must restrict medicaid coverage if the individual is otherwise eligible for medicaid.

(E) The following transfers for less than fair market value shall not be considered an improper transfer:

(1) The individual may transfer the home, as defined in rule 5101:1-39-31 of the Administrative Code, that is still considered the principal place of residence in accordance with Chapter 5101:1-39 of the Administrative Code to any of the following individuals:

   (a) The individual's spouse, provided:

      (i) The transfer is for the sole benefit of the spouse; and
The individual's spouse does not subsequently transfer the home for less than fair market value; and

Any transfer of the home by the spouse on or after the look-back date shall be reviewed by the administrative agency under the transfer of resources provisions in this rule; and

The amount of the transfer is equal to one hundred per cent of the value of the property established by the county auditor at the time of the transfer, less any amount or portion of the property that is not transferred.

(b) His or her child under the age of twenty-one;

(c) His or her child age twenty-one or over who is blind or permanently and totally disabled as defined in Chapter 5101:1-39 of the Administrative Code.

(d) The individual's adult child who was residing in the home for at least two years immediately before the date the individual becomes institutionalized, and who provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility. A JFS 03697 "Level of Care (LOC) Assessment" (rev. 4/2003) must be completed to determine if the individual would have required institutionalization from the beginning and throughout the two-year period if the adult child had not provided personal care.

(e) The individual's sibling who has an equity interest (must be a documented, legal interest) in the home and was residing in the home for at least one year immediately before the individual became institutionalized.

(2) The individual may transfer resources other than a home, subject to paragraph (F) of this rule, as follows:

(a) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(b) From the individual's spouse to another for the sole benefit of the individual's spouse.

(c) To the individual's child, or to a trust established solely for the benefit of the individual's child, who is blind or permanently and totally disabled as defined in Chapter 5101:1-39 of the Administrative Code.

(d) To a trust established for the sole benefit of an individual under sixty-five years of age who is blind or permanently and totally disabled as defined in Chapter 5101:1-39 of the Administrative Code.

(F) As used in this rule, a "transfer for the sole benefit" is a transfer that cannot, under any circumstance, benefit any individual or entity except the spouse, blind or disabled child, or disabled individual, at the time of the transfer or at any time after the transfer.

(1) In order for a transfer to be considered for the sole benefit of the spouse, blind or disabled child, or disabled individual, the entity that receives or holds the transferred resource must, by the explicit terms of a contract, trust, or other binding instrument, be required to expend all of the transferred resources for the benefit of the individual during that individual's life expectancy. When the contract, trust or other binding instrument does not contain such a requirement, the provisions governing transfers for the sole benefit do not apply. A transfer for the sole benefit of the spouse, blind or disabled child or disabled individual in which there is a provision within the trust, contract or other binding instrument to expend all of the transferred resources may provide for other beneficiaries.

(2) A trust may provide for reasonable compensation for a trustee to manage the trust, as well as for reasonable costs associated with managing the trust or managing the property held in the trust. In determining what is reasonable, the administrative agency shall consider the amount of time and effort involved in managing the trust, as well as the prevailing rate of compensation for trustees administering trusts of similar size and/or complexity.
(G) Any transfer between spouses in order to comply with the medicaid community spouse resource allowance (CSRA) computed pursuant to Chapter 5101:3-39 and Chapter 5101:6-7 of the Administrative Code may not be applied inconsistently with the rules setting limits on the CSRA or the minimum monthly maintenance needs allowance (MMNMA).

1. Any amount of a couple's resources exceeding the CSRA must be used for the benefit of the institutionalized spouse and/or community spouse.

2. Any amount of a couple's resources exceeding the CSRA may not be transferred to the community spouse or to another for the sole benefit of the community spouse unless permitted in a hearing decision issued under Chapter 5101:6-7 of the Administrative Code.

3. Any amount of a couple's resources exceeding the CSRA may not be converted to another form for the purpose of generating additional income for the community spouse unless permitted in a hearing decision issued under Chapter 5101:6-7 of the Administrative Code.

4. Transfers in excess allowed by this rule, must be presumed an improper transfer.

(H) Verification of property transfers.

1. The administrative agency shall determine at the time of application, reapplication or upon discovery whether the individual executed a transfer of real or personal property and, if so, whether the transfer was an improper transfer.

2. The administrative agency shall initiate an inquiry regarding potential improper transfers if any source of information tends to show a transfer has occurred.

3. The individual is obligated to obtain documentation verifying any transfer and the details of any exchanges or transactions; however the administrative agency, if requested, shall assist the individual in their attempt to obtain documentation verifying any transfer and the details of any exchanges or transactions. Appropriate documentation may include but is not limited to the following:

   a. Deeds and mortgage statements.

   b. True and correct copies of federal income and gift tax returns that have been filed singly or jointly during the five tax years prior to the application.

      i. At reapplication, the individual may be required to update the returns by providing true and correct copies of all federal and/or state income and gift tax returns, amended tax returns, and schedules that have been filed since the initial application or last reapplication.

      ii. If the individual has not retained copies of federal income and gift tax returns and schedules, the individual must secure copies from the internal revenue service, the preparer of the returns, the accountant completing the return, or any other source where the returns are on file.

      iii. If the individual states that they have not filed federal tax returns for some or all of the required years, the individual's statement is sufficient as long as there is no available information to the contrary.

      iv. When there is some indication that the individual received income or made a substantial gift during any of those years, the individual must provide copies of tax returns or must provide a statement from the internal revenue service confirming the individual did not file tax returns for those years.

4. The administrative agency shall utilize tax returns only to assist in establishing whether the individual executed an improper transfer.

5. The administrative agency must retain copies of the tax returns and schedules in the individual's case record. The original returns provided by the individual shall be returned subsequent to verification of any transfers of real or personal property. The tax returns, schedules, and all
Restricted medicaid coverage due to improper transfers.

(1) If any individual, as defined in paragraph (B)(7) of this rule, applying for or in receipt of LTCF services, HCBS or PACE, improperly transfers resources, the individual, who is applying for or in receipt of LTCF services, HCBS or PACE will be eligible only for restricted medicaid coverage.

(a) The restricted medicaid coverage period is set by the terms of this rule unless otherwise specified or qualified by the provision of another rule.

(b) If the presumption of improper transfer is not overcome by the individual's rebuttal, the administrative agency shall approve restricted medicaid coverage if the individual meets all other eligibility requirements.

(2) The administrative agency must scrutinize all medicaid individuals for improper transfers since an individual may enter a LTCF or qualify for HCBS or PACE at a later date.

(3) If the administrative agency determines that a non-institutionalized medicaid individual improperly transferred resources, the administrative agency shall employ a tracking system to keep an account of these individuals should they apply at a later date for LTCF payment assistance, HCBS or PACE. If the individual enters a LTCF or is in receipt of HCBS or PACE within sixty months from the date of the improper transfer, a restricted medicaid coverage period shall be calculated in accordance with this rule.

Calculating the restricted medicaid coverage period.

(1) For improper transfers of resources that occur prior to February 8, 2006, the period of restricted medicaid coverage is determined as follows:

(a) Divide the total uncompensated value of the transferred resources as of the date of application by the average monthly private pay rate for a LTCF at the later of the date of application or the date of the transfer. There is no limit to the amount of time a period of restricted coverage may run.

(b) The period of restricted coverage begins the first day of the month the resources were transferred unless the exception in paragraph (J)(1)(c) of this rule applies.

(c) When an additional improper transfer occurs prior to February 8, 2006 and during an existing period of restricted medicaid coverage, the penalty period for the additional improper transfer cannot begin until the existing penalty period has expired.

(2) For improper transfers of resources that occur on or after February 8, 2006, the period of restricted medicaid coverage is determined as follows:

(a) Add the total uncompensated value of all improperly transferred resources.

(b) Divide the total uncompensated value of all improperly transferred resources by the average monthly private pay rate for a nursing facility in Ohio in effect at the date of application. This quotient is the total restricted medicaid coverage period in months.

(c) Multiply the average monthly private pay rate for a nursing facility in Ohio by the number of whole months determined in paragraph (J)(2)(b) of this rule. The product is the whole months' improper transfer amount.

(d) Subtract the whole months' improper transfer amount determined in paragraph (J)(2)(c) of this rule from the total uncompensated value of all improperly transferred resources. The remainder is the partial month restricted coverage amount for the final month of restricted medicaid coverage period. The number of whole months from paragraph (J)(2)(c) of this rule and the partial restricted coverage month in paragraph (J)(2)(d) of this rule are added together for the total number of months of restricted medicaid coverage.
(e) The final partial month amount determined in paragraph (J)(2)(d) will be added to the patient liability in the first month of eligibility for payment for long term care services, HCBS, or PACE. Reference rule 5101:1-39-24 of the Administrative Code for the determination of the patient liability.

(f) There is no time limit for a period of restricted medicaid coverage to run.

(g) The administrative agency shall not round down, or otherwise disregard, any fractional restricted medicaid coverage period.

(K) Determining the beginning date of a restricted medicaid coverage period.

(1) For improper transfers that occur prior to February 8, 2006:
   (a) The restricted medicaid coverage period begins the first day of the month assets were transferred for less than fair market value unless the exception in paragraph (K)(1)(b) of this rule applies.
   (b) The penalty period for additional improper transfers, occurring during an existing restricted medicaid coverage period, cannot begin until the existing penalty period has expired.

(2) For improper transfers that occur on or after February 8, 2006, the restricted medicaid coverage period begins the later of:
   (a) The first day of the month during or after which assets were transferred for less than fair market value; or
   (b) The date on which the individual is eligible for medical assistance and would otherwise be receiving long term care services in a LTCF, under an HCBS waiver program, or under the PACE program, based on an approved application for such care but for the application of the penalty period.
   (c) If additional improper transfers occur during an existing restricted Medicaid coverage period, the period must be recalculated to include the uncompensated value of the additional improperly transferred resources.

(L) Notification.

(1) The administrative agency shall deny or terminate medicaid payment to the facility, HCBS waiver or PACE eligibility by using the appropriate form or an electronic eligibility system equivalent when an improper transfer has occurred.

(2) The administrative agency shall issue the appropriate form or an electronic eligibility system equivalent to authorize all other medicaid covered services.

(3) The denial or the termination notice shall note the date medicaid payment to the facility shall start if all other eligibility criteria is met.

(4) The administrative agency must issue proper notice and hearing rights outlined in division 5101:6 of the Administrative Code.

(M) Assets transferred for less than fair market value are returned to the individual.

(1) When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed.

(2) Return of the assets in question to the individual leaves the individual with assets which must be counted in determining eligibility during the original restricted medicaid coverage period. Counting those assets as available may result in the individual being ineligible for medicaid for some or all of the original restricted medicaid coverage period, as well as for a period of time after the assets are returned. The administrative agency must redetermine eligibility for each month in the restricted medicaid coverage period and include the returned assets as an available resource unless the asset would have otherwise been considered an exempt asset. If
an exemption does not apply, the asset is considered available to the individual until the total countable assets have been reduced to the appropriate resource limit.

(3) To void imposition of a restricted medicaid coverage period, all of the assets in question or their fair market value equivalent must be returned. If the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor, either in cash or another form that is commensurate with the original value.

(4) When only part of the asset or its equivalent value is returned, a restricted medicaid coverage period can be modified but not eliminated. For the purpose of computing an overpayment under rule 5101:1-38-20 of the Administrative Code, the returned asset or its equivalent must be considered an available asset beginning in the month the asset was originally transferred.

(N) **Undue hardship.**

(1) The individual, otherwise eligible for medical assistance, will not be subject to restricted medicaid coverage resulting from an improper transfer if restricted medicaid coverage will result in an undue hardship.

(2) An undue hardship exists when application of the restricted medicaid coverage would deprive the individual of the following:

(a) Medical care such that the individual's health or life would be endangered; or

(b) Food, clothing, shelter, or other necessities of life.

(3) **Individual responsibilities.**

(a) To be considered for an undue hardship, the individual must request the undue hardship in writing.

(b) An undue hardship exemption may be requested by the following:

(i) The individual;

(ii) The authorized representative; or

(iii) With the consent of the individual or authorized representative, the nursing facility in which the individual resides.

(c) The individual must document, to the satisfaction of the administrative agency, a good faith attempt was made to recover or make the resource available.

(d) The individual or facility making the request for an undue hardship exemption has the burden of proving all elements and requirements by clear, convincing, and credible evidence, including that an undue hardship exists or will exist and that a good faith effort was made to recover or make the resources available.

(e) When the individual resides in a LTCF, the individual or facility making the request for an undue hardship must prove the individual is in jeopardy of losing the food or shelter due to a planned discharge resulting from the imposition of a restricted medicaid coverage period. The individual will not be found to be in jeopardy unless both of the following are established:

(i) The individual or the individual's representative must first exhaust all legal remedies and appeals to challenge the planned discharge; and

(ii) The facility must document that it has exhausted all legal remedies to collect, reconvey, or recover the improperly transferred assets, including but not limited to actions authorized under section 1336.01 of the Revised Code, or any other similar law of another jurisdiction. The facility is not required to pursue a legal action if it can document the cost of such an action would exceed the gross value of the assets subject to recovery in a legal action.

(4) **Administrative agency responsibilities.**
(a) The administrative agency shall provide notice to the individual of the:

(i) Availability of an undue hardship.

(ii) Decision of a request for an undue hardship exemption due to a transfer of assets that results in a restricted coverage period during which medicaid payment for long term care services will not be made.

(b) The administrative agency, may on its own initiative, consult with the county prosecutor to determine whether a civil or criminal action may be brought to recover the transferred assets or to compel restitution.

Replaces: 5101:1-39-07
Effective Date: 10/20/2006
R.C. 119.032 review dates: 10/01/2011
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MEMTL 92

Effective Date: January 15, 2015

(A) This rule describes the social security administration’s (SSA) reporting requirements to the Ohio department medicaid (ODM) of alleged transfer of resources by supplemental security income (SSI) applicants.

(B) When an individual applies for SSI benefits, SSA shall inform the individual of the medicaid policy regarding transfer of resources and inquire whether or not the individual has transferred any resources.

(C) The SSA obtains from all SSI applicants the following information regarding an alleged resource transfer and provides this information to ODM:

1. A description of the resources transferred (e.g., real estate, automobile, stocks, cash, etc.);
2. The name of the party to whom the resource was transferred;
3. The amount of compensation received or expected;
4. The approximate value of the transferred resource;
5. The date the resource was transferred;
6. Whether the applicant was the sole owner of the resource and, if not, the names of any co-owners;
7. The relationship of the applicant, if any, to the individual to whom the resource was transferred.

(D) The ODM will forward the information to the CDJFS in which the individual resides.

(E) The CDJFS will review the alleged transfer of resources and, if the individual is a medicaid applicant or recipient, determine or redetermine continued medicaid eligibility in accordance with Chapter 5160:1-3 of the Administrative Code.

Replaces: 5160:1-3-06
Effective: 01/15/2015
Five Year Review (FYR) Dates: 01/15/2020
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Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 8/9/90, 10/1/02
This rule describes the disposal of resources for Ohio department of developmental disabilities (DODD) and/or Ohio department of mental health and addiction services (ODMHAS) individuals in receipt of medical assistance.

Individuals in receipt of medical assistance may have received or continue to receive services from the DODD and/or the ODMHAS.

1. DODD and ODMHAS provide for any and all personal needs, e.g., recreational activities and services necessary to assure a better quality of life for individuals under their care. Many of these services are not covered by Medicaid and exceed the individual's available personal income.

2. DODD and ODMHAS maintain records and documentation of expenses incurred on an individual's behalf that fall outside the scope of Medicaid coverage and exceed the individual's available income.

3. When an individual receives a lump-sum payment or available resources are identified, DODD and ODMHAS seek reimbursement for appropriately incurred expenses.

When DODD and/or ODMHAS are acting on behalf of the individual as the responsible party, legal guardian, etc., the appropriate department may dispose of the resource by increasing the individual's resources to the resource limit, establishing an irrevocable burial agreement, and purchasing any personal items deemed necessary to better the individual's quality of life. After these expenses, DODD and/or ODMHAS will reimburse their department for funds expended on behalf of the individual and provide documentation of these expenses to the administrative agency.

If the individual's responsible party, legal guardian, etc., is not a representative of DODD and/or ODMHAS, the representative is also afforded the opportunity of increasing resources to the resource limit, establishing an irrevocable burial agreement, and purchasing necessary personal items. Documentation of these expenses shall be provided to the administrative agency. After such expenses, the responsible party, legal guardian, etc., must properly dispose of any excess resource to maintain continued medical assistance eligibility.

Administrative agency responsibilities. The administrative agency shall:

1. Notify the responsible party of the options available to appropriately dispose of excess resources. One option is reimbursement to ODM for Medicaid expenses. However, the options of reimbursing ODM, DODD, or ODMHAS or terminating Medicaid and paying privately for the medical expenses remain with the responsible party.

2. Review necessary documentation for the reimbursement to DODD or ODMHAS to assure that the recipient did, in fact, receive fair and equitable value for the resources.

   a. If the documentation verifies the individual received fair and equitable value, the administrative agency shall accept these expenditures as valid.

   b. Valid expenses and reimbursements to DODD and/or ODMHAS shall not be considered an improper transfer of resources.
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 4/1/89 (Emer.), 11/7/02
MEMTL 85

Effective Date: November 1, 2013

Most Current Prior Effective Date: December 1, 2006

(A) This rule defines how income is treated for purposes of determining patient liability for individuals receiving long-term care services in a long-term care facility, under a home and community-based services (HCBS) waiver program, or under the program of all-inclusive care for the elderly (PACE).

(B) Definitions.

(1) "Administrative agency" means the county department of job and family services, the Ohio department of job and family services (ODJFS), or other entity that determines eligibility for a medical assistance program.

(2) "Community spouse" means an individual who is not in a medical institution or nursing facility and has an institutionalized spouse. This includes an individual requesting or receiving services under an HCBS waiver program or PACE whose spouse is institutionalized in a medical institution or nursing facility, except that neither of two spouses, married to each other, who both request or receive services under an HCBS waiver program or PACE is considered to meet this definition a community spouse.

(3) The "excess shelter allowance (ESA)" means the community spouse's expenses for the principal place of residence, including: rent or mortgage payment (including principal and interest), taxes and insurance, any required maintenance charge for a condominium or cooperative, and, if applicable, the established standard utility allowance, minus the ESA standard.

(4) The "excess shelter allowance standard" means thirty per cent of the minimum monthly maintenance needs allowance (MMMNA) standard.

(5) "Family allowance" means a deduction in the computation of patient liability, for needs of certain dependent family members residing with a community spouse. The family allowance, calculated separately for each family member, is one-third of the MMMNA standard, less the gross amount of the monthly income of the family member, then rounded down to the nearest whole dollar.

(6) The "family allowance need standard" means one-third of the MMMNA. The family allowance need standard is adjusted annually in accordance with the federal poverty level (FPL).

(7) "Family maintenance needs allowance" means a deduction in the computation of patient liability for needs of certain dependent family members when there is no community spouse. The family maintenance needs allowance is the family maintenance needs allowance standard for the total number of dependent family members, less the gross combined monthly income of the family members, then rounded down to the nearest dollar.

(8) The "family maintenance needs allowance standard" means the Ohio works first payment standard for the same number of applicable dependent family members.

(9) "Family member" means a natural, adoptive, or step-child or parent or sibling of the individual who:

(a) For the purpose of determining a family allowance:

(i) Is claimed as a dependent by the institutionalized spouse, the community spouse, or the couple, for the most recent federal tax year, or, if a tax return was not filed, could be claimed as a dependent; and

(ii) Is residing with the community spouse.

(b) For the purpose of determining a family maintenance needs allowance:
Is claimed as a dependent by the institutionalized individual for the most recent tax year, or, if a tax return was not filed, could be claimed as a dependent; and

Has resided with the institutionalized individual immediately preceding the institutionalized individual's admission to the nursing facility or is residing with the individual who is enrolled in an HCBS waiver or PACE.

The "federal poverty level (FPL)" means a set of guidelines, issued each year by the United States department of health and human services (HHS), as a poverty measure for administrative purposes such as determining financial eligibility for certain federal programs.

"Home and community-based services (HCBS)" are defined in accordance with rule 5101:1-38-01.6 of the Administrative Code.

"HCBS waiver agency" means the ODJFS, or its designee that performs administrative functions related to an HCBS waiver program, in accordance with rule 5101:1-38-01.6 of the Administrative Code and division 5101:3 of the Administrative Code.

An "individual" means an applicant for or recipient of a medical assistance program.

"Institutionalized", for the purpose of this rule, describes an individual who receives long term care services in a medical institution, a long term care facility, intermediate care facility for the mentally retarded (ICF-MR), under an HCBS waiver program, or under PACE.

"Institutionalized spouse" means an individual who:

(a) Receives long term care services in a medical institution, a long term care facility, intermediate care facility for the mentally retarded (ICF-MR), under an HCBS waiver program, or under PACE for at least thirty consecutive days; and

(b) Is married to a spouse who is not in a medical institution or a nursing facility.

A "long-term care facility (LTCF)" means a medicaid-certified nursing facility, skilled nursing facility, or intermediate care facility for persons with mental retardation as defined in division 5101:3 of the Administrative Code.

"Long-term care services" mean medicaid-funded, institutional or community-based, medical, health, psycho-social, habilitative, rehabilitative, and/or personal care services that may be provided to medicaid-eligible individuals, as defined in rule 5101:3-3-15 of the Administrative Code.

"Medicaid cost of care" means:

(a) For an individual in a LTCF, the medicaid per diem rate for each LTCF; or

(b) For an individual receiving services under an HCBS waiver program, the medicaid cost of care for waiver-approved services in accordance with the individual's plan of care, or

(c) For an individual receiving services under PACE, the PACE capitated rate.

The "minimum monthly maintenance needs allowance (MMMNA)" means the MMMNA standard plus the excess shelter allowance (ESA).

(a) Except in accordance with rule 5101:6-7-02 of the Administrative Code, the MMMNA must not exceed the MMMNA cap which is updated annually by the same percentage increase in the consumer price index.

(b) The MMMNA may be increased in accordance with rule 5101:6-7-02 of the Administrative Code.

The "minimum monthly maintenance needs allowance standard" means one hundred fifty per cent of the federal poverty level (FPL) for a family unit of two members.

"Monthly income allowance" for a community spouse means a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.
"Patient liability" means the individual's financial obligation toward the medicaid cost of care.

"Personal needs allowance" means a required deduction in the computation of patient liability, for needs of the individual. The personal needs allowance for individuals who request or receive services under an HCBS waiver program is referred to as a "special individual maintenance needs allowance." Personal needs allowance retained beyond the month of allocation is treated as a resource and subject to resource requirements of Chapter 5101:1-39 of the Administrative Code.

"Plan of care" means the written document that specifies the HCBS waiver and other services (regardless of funding source) along with any informal supports that are furnished to meet the needs of and to assist a waiver participant to remain in the community. The plan contains, at a minimum, the types of services to be furnished, the amount, the frequency and the duration of each service and the type of provider to furnish each service.

"Program of all-inclusive care for the elderly (PACE)" means a medical assistance program, approved by the centers for medicare and medicaid services (CMS), for certain elderly individuals.

The "special income level" means an amount, in accordance with rule 5101:1-39-21 of the Administrative Code, equal to three hundred per cent of the current supplemental security income (SSI) payment standard for an individual, as published annually by the social security administration.

The "special individual maintenance needs allowance" means a required deduction in the computation of patient liability, for needs of the individual who requests or receives HCBS under an HCBS waiver program in accordance with rule 5101:1-39-23 of the Administrative Code, or for the needs of the individual living in a community setting who requests or receives services under the PACE. The special individual maintenance needs allowance is sixty-five per cent of the special income level, in accordance with rule 5101:1-39-21 of the Administrative Code.

A "spouse" means a person legally married to another under Ohio law.

The "standard utility allowance" means an amount that is used in lieu of the actual amount of utility costs; the standard utility allowance is applicable if the community spouse is responsible for payment toward the cost of gas, electric, coal, wood, oil, water, sewage, or telephone for the residence.

Administrative agency responsibilities.

(1) The administrative agency must determine medicaid eligibility in accordance with the eligibility rules contained in Chapters 5101:1-37 to 5101:1-42 of the Administrative Code.

(2) The administrative agency must determine the individual's patient liability by utilizing the following procedure, in sequence, subsequent to notification of an appropriate level of care, and, if applicable, HCBS waiver agency approval or PACE site approval:

(a) Total all income, earned and unearned, of the individual, without applying any exemptions or disregards; then

(b) Exclude the following as income for the purposes of determining patient liability:

(i) German reparation payments, Austrian social insurance payments, and Netherlands reparation payments, in accordance with the Nazi Persecution Victims Eligibility Act, Pub. L. No. 103-286 or provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506, as in effect on August 1, 1994.

(iii) Agent Orange settlement payments under the provisions of the Agent Orange Compensation Exclusion Act, Pub. L. No. 101-201, as in effect on January 1, 1989, received on or after January 1, 1989.


(v) Veterans administration reduced pensions under 38 U.S.C. 5503, as in effect on November 10, 2005, up to the amount of ninety dollars per month, paid to veterans in a nursing facility. This reduced pension applies to the following individuals:

(a) A veteran without a spouse or child; and
(b) A veteran's surviving spouse without a child.

(vi) The first ninety dollars of veterans administration aid and attendance pensions paid to veterans or their widows who are receiving HCBS waiver services and who have no dependent minor or disabled children.


(viii) SSI benefits received under authority of sections 1611(e)(1)(E) and (G) of the SSA, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, as in effect on December 22, 1987, for institutionalized individuals, during the first three full months of institutionalization. The administrative agency must not retroactively redetermine patient liability determinations, made under the continued benefit provision, if the recipient's actual stay exceeds the expected stay of ninety days or less.

(ix) Residential state supplement (RSS) benefits to institutionalized individuals, in accordance with rule 5101:1-17-05 Chapter 5101:1-17 of the Administrative Code.

(x) Payments received under the provisions of a state "Victims of Crime Program", Pub. L. No. 103-322, as in effect on September 13, 1994.

(xi) Cost-of-living subsidies, including, but not limited to, start-up funds and one-time or other housing allowances, provided by the Ohio department of mental retardation and developmental disabilities (ODMR/DD) or county boards of mental retardation and developmental disabilities to individuals enrolled in a medicaid waiver administered by the ODMR/DD pursuant to section 5111.871 of the Revised Code.


(xiii) Payments made from any fund established pursuant to a class action settlement in the case of "Factor VIII or IX concentrate blood products litigation," MDL986, no. 93-C-7452 (N.D. Ill), per section 4735 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, as in effect on August 5, 1997.

(xiv) In the case of an individual who has no spouse, only the income of that individual is considered in the patient liability determination.

(xv) For the month following the month of institutionalization, an institutionalized child is treated as an individual living alone. Only the child's own income is considered in the patient liability determinations.
Spouses separated by a continuous period of institutionalization, are considered to be living apart starting in the month the institutionalized spouse enters the institution. Only the income allocated to the institutionalized spouse is considered available in the patient liability determination.

Effective through December 31, 2005, neither the six hundred dollar credit nor any discount savings arising from the medicare-approved drug card must be counted as income in the patient liability budget process.

The administrative agency must subtract the appropriate personal needs allowance for the needs of the individual. Appropriate personal needs allowances are:

(i) For individuals who are nursing facility or ICF-MR residents and have no earned income: forty dollars;

(ii) For individuals who are nursing facility or ICF-MR residents and have earned income: forty dollars plus up to an additional sixty-five dollars of gross earnings received as a result of employment, up to a combined maximum of one hundred five dollars;

(iii) For HCBS waiver eligible individuals who have no earned income: the special individual maintenance needs allowance;

(iv) For HCBS waiver eligible individuals who have earned income: the special individual maintenance needs allowance plus up to an additional sixty-five dollars of gross earnings received as a result of employment.

The administrative agency must compute and subtract a monthly income allowance for the individual's community spouse, if applicable, utilizing the following steps, except in the case that two spouses, married to each other, are both eligible for and receiving services under a HCBS waiver program or PACE:

(i) Total housing expenses of the community spouse: rent, mortgage payment (including principal and interest), taxes and insurance, condominium or cooperative required maintenance charges, and (if applicable) the established standard utility allowance, rounding the total down to the nearest whole dollar; then,

(ii) Subtract the excess shelter allowance standard;

(iii) The remainder is the excess shelter allowance (ESA);

(iv) Add the ESA and the MMMNA standard to determine the MMMNA (this amount must not exceed the cap on the MMMNA);

(v) Subtract the community spouse's total gross income from the lesser of the MMMNA or the cap on the MMMNA;

(vi) The remainder, (rounded down to the nearest whole dollar), is the monthly income allowance for the community spouse, unless the amount of court ordered support is greater, in which case the court ordered amount is used as the monthly income allowance.

(vii) All available income of the institutionalized spouse must be transferred to the community spouse and determined insufficient to meet the monthly income allowance before a substituted community spouse resource allowance is considered in accordance with rule 5101:6-7-02 of the Administrative Code.

(viii) The monthly income allowance from an institutionalized individual to a community spouse who is either an HCBS waiver-eligible individual or a PACE eligible individual must be treated as unearned income to the community spouse in the determination of eligibility for medical assistance and patient liability.
The administrative agency must compute and subtract, if applicable, a family allowance for each family member, utilizing the following steps: An institutionalized spouse and an HCBS waiver eligible spouse or a PACE eligible spouse, married to each other, the family allowance must be deducted in the patient liability calculation of only one of the individuals. The family allowance provided from the institutionalized spouse must be treated as unearned income.

(i) For each family member, multiply the MMMNA standard by one-third; then
(ii) Subtract that family member's gross monthly income; then
(iii) Round the result down to the nearest dollar.
(iv) The remainder is the family allowance for that family member.
(v) The family allowances for each family member are added together to determine the total family allowance.

The administrative agency must compute and subtract, if applicable, a family maintenance needs allowance utilizing the following steps:

(i) Subtract the combined monthly income of the family members from the family maintenance needs allowance standard; then
(ii) Round the result down to the nearest dollar.
(iii) The remainder is the family maintenance needs allowance.

The administrative agency must subtract the individual's medical expenses not subject to third party payment, including:

(i) Medicaid, medicare, or other health insurance premiums;
(ii) Insurance deductibles, coinsurance, or copayments;
(iii) Necessary medical or remedial care, recognized under Ohio law, but not covered by medicaid and not subject to third party payment;
(iv) Unpaid past medical expenses, excluding cost of care already used to meet the individual's spenddown.

The remainder is the individual's patient liability for a full month of institutionalization.

The administrative agency must prorate the patient liability when the individual is institutionalized for less than a full month due to death, discharge from the nursing facility or HCBS waiver or PACE program, or initial intake. To calculate a prorated patient liability, the administrative agency must:

(i) Determine the per diem patient liability by dividing the patient liability for a full month of institutionalization by the number of days in the month for which the prorated payment is to be determined.
(ii) Determine the actual number of days of institutionalization in the month for which the prorated payment is to be determined, including the first date of institutionalization. The date of discharge or the date of death is not included in this calculation.
(iii) Multiply the actual number of days of institutionalization by the per diem amount, rounding down to the nearest dollar. This is the individual's prorated patient liability.

When an individual who is already receiving medicaid becomes institutionalized, the administrative agency shall issue proper notice of adverse action before requiring a patient liability.

The administrative agency must recalculate the patient liability when notified of changes that may affect the patient liability amount.
(4) The administrative agency must notify the institution, HCBS waiver agency, or PACE site of the patient liability, changes to patient liability, and retroactive patient liability adjustments.

(5) The administrative agency must provide written notification to the individual of the determination of medical assistance eligibility, changes to patient liability, and the amount of patient liability, if applicable.

(6) The administrative agency must issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

(D) The individual must pay the patient liability amount to the entity as directed.

(E) The long-term care facility must:

(1) Accept the patient liability amount from the individual.

(2) Refund overpayments of patient liability to the individual, such as when retroactive patient liability adjustments are made.

(F) The HCBS waiver agency must notify the individual as to whom to make patient liability payment.

(G) The PACE site must notify the individual as to whom to make patient liability payment.

(H) The administrative agency must provide appropriate notice to the individual, and the individual's community spouse, if applicable, including the monthly income allowance (MIA) and appeal rights, the amounts deducted in the calculation of patient liability, and the determination of ownership and availability of income.

(I) The administrative agency must issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

Effective: 11/01/2013

R.C. 119.032 review dates: 04/01/2013 and 11/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 10/15/2013

Promulgated Under: 111.15

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Rule Amplifies: 5111.01, 5111.011

Prior Effective Dates: 6/1/88 (Emer.), 8/1/88 (Emer.), 10/30/88, 1/1/90 (Emer.), 3/1/90 (Emer.), 3/30/90 (Emer.), 4/1/90, 6/29/90, 7/1/90, 10/1/90, 1/1/91 (Emer.), 4/1/91, 1/1/92 (Emer.), 3/20/92, 5/1/92 (Emer.), 7/1/92, 8/14/92 (Emer.), 11/1/92, 5/1/93, 9/1/93, 7/1/94, 1/1/95 (Emer.), 3/20/95, 10/1/95, 4/1/96, 1/1/97 (Emer.), 2/9/97, 12/31/97 (Emer.), 2/1/98, 4/1/99, 1/1/00, 1/1/01, 5/12/02, 7/01/05, 12/01/06
Most Current Prior Effective Date: July 1, 2006

Effective Date: September 15, 2006

(A) For individuals enrolled in the assisted living waiver, this rule defines how the administrative agency will:

1. Compute income to determine medicaid eligibility, and
2. Determine patient liability.

(B) Definitions. All definitions found in rules 5101:1-39-23 and 5101:1-39-24 of the Administrative Code apply to the content of this rule, with the following additions:

1. "Assisted living facility" means a facility certified by the Ohio department of aging in accordance with rule 173-39-02 of the Administrative Code.
2. "Assisted living waiver (ALW)" means the home and community based services waiver approved by the federal centers for medicare and medicaid services (CMS). The waiver provides an alternative to nursing facility placement for persons aged twenty-one and over who require intermediate or skilled care. Services and eligibility criteria for the waiver are found in rules 5101:3-1-06.5 and 5101:3-33-02 to 5101:3-33-07 of the Administrative Code.
3. "Assisted living waiver maintenance needs allowance (ALMNA)" means the amount equal to the supplemental security income (SSI) federal benefit rate, which is a required deduction in the computation of patient liability for those enrolled in the ALW. This amount is to be used for the needs of an individual enrolled in the ALW. For these individuals, the ALMNA is used in lieu of the special individual maintenance needs allowance found in rule 5101:1-39-24 of the Administrative Code.
4. "Personal needs allowance" for individuals enrolled in the ALW is a required deduction in the computation of patient liability. It is the total of the ALMNA plus up to sixty-five dollars for those individuals who receive earnings from employment.
5. "SSI federal benefit rate" means the monthly amount issued by the social security administration to individuals receiving SSI cash payments. It is adjusted each year effective the first of January.

(C) The administrative agency must:

2. Process requests for enrollment into the ALW in accordance with this rule, and rules 5101:1-38-01.6 and 5101:3-33-04 of the Administrative Code.
3. Determine if the individual meets the income criteria for medicaid eligibility for coverage of services under the ALW program, using the same methodology found in rule 5101:1-39-23 of the Administrative Code.
4. Determine patient liability in accordance with the methodology found in rule 5101:1-39-24 of the Administrative Code, with the following exceptions:

(a) Calculate the personal needs allowance by using the following methodology:

(i) Determine the current SSI federal benefit rate.
(ii) For individuals who have no earned income, the SSI federal benefit rate amount is the ALMNA.
For individuals who have earned income as a result of employment, the ALMNA is the total of the following two amounts:

(a) The SSI federal benefit rate, and

(b) Up to a maximum of sixty-five dollars of the gross earnings received as a result of employment.

The ALMNA is used as the personal needs allowance for ALW eligible individuals in the calculation of patient liability.

The remainder, after subtracting all other applicable exemptions and deductions listed in rule 5101:1-39-24 of the Administrative Code, is the individual's patient liability.

The individual must pay the patient liability amount to the facility in accordance with rule 5101:1-39-24 of the Administrative Code.

The administrative agency must issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.


Effective: 09/15/2006

R.C. 119.032 review dates: 09/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 09/05/2006

Promulgated Under: 111.15

Statutory Authority: 5111.01

Rule Amplifies: 173.40, 5111.01, 5111.89

Prior Effective Dates: 7/1/06 (Emer)
MEMTL 33

Effective Date: October 1, 2006

Most Current Prior Effective Date: November 7, 2002

(A) This rule describes the consideration of property agreements as resources.

(B) Definitions.

(1) "Administrative agency" means the county department of job and family services, the Ohio department of job and family services, or other entity that determines eligibility for a medical assistance program.

(2) "Arms Length" is the description of an agreement made by two parties freely and independently of each other, and without some special relationship, such as being a relative, having another deal on the side or one party having complete control of the other.

(3) "Assets" are defined in rule 5101:1-39-05 of the Administrative Code.

(4) "Individual" means an applicant or recipient of a medical assistance program.

(5) "Look-back period" has the same meaning as defined in rule 5101:1-39-07 of the Administrative Code.

(6) "Property agreements" mean a pledge or security of a particular property for the payment of a debt or the performance of some other obligation within a specified period.

(a) Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, etc.

(b) Personal property agreements (e.g., pledges of crops, fixtures, inventory, etc.) are commonly known as chattel mortgages.

(7) "Negotiable instrument" means a written instrument that is signed by the maker or drawer that includes an unconditional promise or order to pay a specified sum of money, is payable on demand or at a definite time, and is payable to order or to bearer.

(C) Treatment of property agreements.

(1) The administrative agency must determine the effective date of a property agreement as follows. The recording date is the date the property agreement is recorded with the county auditor, county recorder, or other appropriate governmental agency charged with the responsibility of recording real estate transfers and titles. The date of signature is the date that the person authorized to enter into the property agreement actually signed the instrument creating the agreement.

(a) For property agreements that are recorded within six months after the date of signature, the administrative agency must consider the date of signature to be the effective date of the agreement.

(b) If a property agreement is recorded more than six months after the date of signature, the individual must produce documentation from other sources verifying that the agreement was established on the date of signature rather than the date of recording. Such documentation may consist of financial records from lending institutions, tax records from governmental agencies, or records from other agencies or private or public institutions. The individual may provide statements from persons to whom the property was conveyed or from persons who participated in the establishment of the property agreement. The administrative agency must accept the statements of these persons only upon a finding that their statements are...
corroborated and credible. If the applicant/recipient individual fails to produce documentation verifying the date of signature, then the CDJFS shall administrative agency must use the date of recording as the effective date of the agreement.

(c) If a transfer is not recorded at all, the applicant/recipient individual must record the agreement. The applicant/recipient individual must produce documentation evidencing the transfer. Such documentation may consist of financial records from lending institutions, tax records from governmental agencies, or records from other agencies or private or public institutions. The applicant/recipient individual may provide statements from persons to whom the property was transferred or other persons who participated in the creation of the agreement. The CDJFS shall administrative agency must accept the statements of these persons only upon a finding that their statements are corroborated and credible. If the applicant/recipient individual fails to produce documentation verifying the date of signature, then the CDJFS shall administrative agency must use the date of recording as the effective date of the transfer.

(2) A copy of the property agreement must be obtained for the case record.

(3) For a negotiable property agreement, its value as a resource is its outstanding principal balance.

(a) The applicant/recipient individual must receive fair market value as a result of arm’s length negotiations.

(b) The fair market value of the property agreement at the time of the transfer must be equal to the fair market value of the property given by the applicant/recipient individual in exchange for the property agreement.

(c) Fair market value is defined in rule 5101:1-39-05 the resource requirement rule in Chapter 5101:1-39 of the Administrative Code.

(d) To establish the fair market value of the property agreement, the applicant/recipient individual must present documentation from two knowledgeable sources who are regularly engaged in the business of the public trade, sale, or exchange of the type of property agreement presented, attesting to the market value of the property agreement on the date of the transfer.

(4) For non-negotiable property agreements, if the terms of the agreement prohibit or prevent the sale of the agreement, then the assets given in exchange for the agreement will be deemed improperly transferred in accordance with the provisions in rule 5101:1-39-07 the transfer of resources rule in Chapter 5101:1-39 of the Administrative Code if the exchange occurred within the applicable look-back period.

(a) The total value of resources improperly transferred is the value of the assets originally exchanged for the agreement, reduced by the sum total of any repayments made on or before the date of application for medicaid.

(b) The period of restricted coverage shall must not be reduced based upon anticipated, estimated, or projected future payments to be made under the agreement.

(c) The applicant/recipient individual may seek a new eligibility determination and/or a recalculation of the restricted period of coverage based only upon actual repayments made under the terms of the agreement.

(d) If the sum total of all repayments made under the agreement are less than the original value of the assets given in exchange for the agreement, then the difference will be deemed improperly transferred if the exchange occurred within the applicable look-back period.

(5) If the applicant/recipient individual sells a property agreement for an amount less than the value of assets given in exchange for the agreement, the difference will be deemed improperly transferred as of the date of the sale of the agreement. The applicant/recipient individual may rebut the finding of an improper transfer by:
(a) Providing credible evidence from a knowledgeable source establishing that the market value at the time of sale of the agreement was less than its outstanding principal balance. The knowledgeable source must be clearly identified. The knowledgeable source must provide a written explanation regarding its opinion of the market value. The knowledgeable source must affirmatively indicate that the decreased market value was not caused in whole or part by the terms of the agreement and that the decrease in value was entirely outside the control of the applicant/recipient individual or his or her representatives. Knowledgeable sources include anyone regularly engaged in the business of the public trade, sale, or exchange of commercial paper; or,

(b) The applicant/recipient individual may provide documentation clearly showing that the applicant/recipient individual received payments under the terms of the agreement prior to the sale, and that such payments equal or exceed the difference between the sale price and the value of assets originally given in exchange for the agreement; or,

(c) The applicant/recipient individual may provide documentation clearly showing that the lower sale price of the agreement was accepted by the applicant/recipient individual as payment of a debt owed by the applicant/recipient individual to the purchaser.

(6) If ownership of the property agreement is shared, documentation must be provided by the applicant/recipient individual verifying his or her the individual's proportionate share of the agreement.

Replaces: 5101:1-39-32.1
Effective Date: October 1, 2006
R.C. 119.032 review dates: 07/14/2006
Certification:
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011
Rule Amplifies: 5111.01, 5111.011
Effective Date: March 26, 2015

(A) This rule describes medicaid eligibility criteria for children from birth until the individual reaches age nineteen in accordance with 42 C.F.R. 435.118 (as in effect July 1, 2014) for applications for medical assistance filed on or after January 1, 2014.

(B) Definition. "Child", for the purpose of this rule, means an individual younger than age nineteen.

(C) Eligibility criteria for coverage because a newborn child was born to a medicaid-eligible woman (deemed newborn). In accordance with 42 C.F.R. 435.117 (as in effect July 1, 2014), a child is automatically eligible for medicaid as of the child's date of birth, and remains eligible until the child reaches the age of one, provided the birth mother has applied for, been determined eligible for, and is receiving medicaid on the date of the child's birth.

(1) Coverage under this paragraph also applies to newborns under the following circumstances:

(a) When labor and delivery services were furnished prior to the date of application and the birth mother's medicaid eligibility is based on retroactive coverage in accordance with 42 C.F.R. 435.915 (as in effect on July 1, 2014).

(b) While the birth mother is receiving alien emergency medical assistance (AEMA) in accordance with rule 5160:1-1-91 of the Administrative Code.

(c) While the birth mother is residing in a public institution and is:

(i) Restricted from payment of services as referenced in rule 5160:1-1-58.1 of the Administrative Code, and

(ii) Within twelve months from the date of her most recent medicaid application or redetermination.

(d) While the birth mother is in the custody of a public children services agency (PCSA) or private child placing agency (PCPA).

(e) While the birth mother is in receipt of adoption or foster care assistance under Title IV-E.

(f) While the birth mother is in receipt of state or federal adoption assistance.

(g) When the birth mother loses medicaid eligibility after the birth of the newborn.

(h) When the birth mother is no longer a member of the newborn's household at any time prior to the newborn reaching the age of one.

(2) For newborns described in this paragraph, the administrative agency must:

(a) Upon verbal or written notification of the newborn's birth from any individual or entity reporting the birth:

(i) Verify, in the electronic eligibility system, that the birth mother was eligible for and received medicaid on the date of the child's birth, and

(ii) Approve the child's eligibility for medicaid without delay and without consideration of household composition or income.

(b) Not require an application for the child or a redetermination prior to the month of the child's first birthday.

(c) Not require verification of U.S. citizenship or identity.

(d) Complete a redetermination when the child reaches the age of one.

(D) Eligibility criteria for coverage because an individual is in foster care, receives adoption assistance, or is in the custody of a PCSA or PCPA or Title IV-E agency.
A child is eligible for medicaid under this rule, regardless of family size, income, or resources, when the child is in the custody of a PCSA, PCPA, or Title IV-E agency and in receipt of:

(a) Adoption or foster care assistance under Title IV-E of the Social Security Act as in effect July 1, 2014; or

(b) State or federal foster care assistance in accordance with section 1902(e)(14)(D)(i) of the Social Security Act (as in effect July 1, 2014); or

(c) State or federal adoption assistance.

Child, individual, or authorized representative responsibilities. The child, the individual, or the authorized representative must:

(a) Sign and date the application;

(b) Meet the conditions of eligibility described in rule 5160:1-1-58 of the Administrative Code;

(c) Cooperate in establishing eligibility; and

(d) Report changes in accordance with rule 5160:1-1-55 of the Administrative Code.

Eligibility criteria for coverage because an individual is a child under age nineteen.

(1) A child’s family size and household income shall be calculated as described in rule 5160:1-1-61 of the Administrative Code.

(2) If the child is not covered by other creditable coverage, the child's household income must not exceed two hundred six per cent of the federal poverty level for the family size.

(3) If the child is covered by other creditable coverage, the child's household income for the family size must not exceed one hundred fifty-six per cent of the federal poverty level for the family size.

(4) A child receiving medical coverage under this paragraph remains eligible:

(a) Through the end of the month in which the child turns age nineteen, if the child remains otherwise eligible in accordance with rule 5160:1-1-58 of the Administrative Code; or

(b) Until the end of an inpatient stay during which inpatient services are being furnished, if the child is found eligible under this paragraph on or after his/her eighteenth birthday and turns age nineteen during the inpatient stay.
This rule describes medicaid eligibility criteria for applications for medical assistance filed on or after January 1, 2014, for individuals:

1. Who are age nineteen or twenty, or
2. Who aged out of foster care on their eighteenth birthday, are younger than age twenty-six, and are not eligible under rule 5160:1-4-02 of the Administrative Code.

Eligibility criteria for coverage because an individual is age nineteen or twenty in accordance with 42 C.F.R. 435.222 (as in effect July 1, 2014).

1. The individual must be age nineteen or twenty.
2. The individual's family size and household income must be calculated as described in rule 5160:1-1-61 of the Administrative Code.
3. The individual's household income must not exceed forty-four per cent of the federal poverty level for the family size.

Eligibility criteria for coverage because an individual aged out of foster care in accordance with section 1902(a)(10)(A)(i)(IX) of the Social Security Act (as in effect July 1, 2014).

1. The individual must:
   a. Be at least eighteen years old and younger than twenty-six years old;
   b. Have been in foster care under the responsibility of the state on the individual's eighteenth birthday;
   c. Have been eligible for and enrolled in medicaid while in such foster care; and
   d. Cooperate in establishing eligibility, which includes signing and dating the application.

2. Under this paragraph, there is no income test for coverage because an individual aged out of foster care.

Replaces: 5160:1-1-63.1

Effective: 03/26/2015

Five Year Review (FYR) Dates: 03/26/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/16/2015

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02

Prior Effective Dates: 10/1/13
Effective Date: January 1, 2010

Most Current Prior Effective Date: January 1, 2008

(A) This rule describes transitional medical assistance (TMA), which is a covered group of individuals who lose eligibility due to earned income, as described in Section 1925 of the Social Security Act (as in effect on December 1, 2009).

(B) Eligibility criteria under this covered group.

(1) The individual must have received, or be deemed eligible for but not receiving, Ohio works first (OWF) or received low-income families (LIF) medicaid in the state of Ohio in at least three of the six months immediately preceding the month in which the individual becomes ineligible for medicaid.

(2) The family must have lost medicaid eligibility due to receipt of new earned income or increased earned income. Verification of income is not required and can be self-declared.

(3) Eligibility begins the month immediately following the last month the individual received medicaid. Any months of medicaid received in error, due to unreported earned income, are counted as months of transitional medical assistance.

(C) Administrative agency responsibilities. The administrative agency shall:

(1) Verify in the electronic eligibility system the individual was receiving medicaid in previous months. Approve TMA if an individual meets the requirements in paragraph (B) of this rule;

(2) Deny or terminate TMA for an individual if the individual fraudulently received OWF during any of the last six months of the family's OWF eligibility;

(3) Not consider resources;

(4) Terminate or deny TMA when:

(a) There is no longer a dependent child in the family.

(b) The family becomes eligible for another medicaid covered group.

(D) Eligibility under this covered group is for twelve months. An individual who has eligibility terminated prior to the completion of the twelfth month of TMA may potentially re-establish TMA.

(1) Individuals who lose TMA eligibility and subsequently qualify for OWF or LIF medicaid may be eligible for a new period of TMA when eligibility criteria in paragraph (B) of this rule are met. There is no limit to the amount of times an individual re-establishes eligibility for TMA.

(2) Individuals who lose TMA eligibility and subsequently qualify for OWF or LIF medicaid may be eligible for the remainder of the original TMA period when only the eligibility criterion in paragraph (B)(2) of this rule is met.
Rule Amplifies: 5111.01, 5111.011, 5111.019

Prior Effective Dates: 04/01/90 (Emer.), 06/22/90, 10/01/90, 01/01/93, 04/21/94, 10/31/97 (Emer.), 01/26/98, 06/01/02, 08/30/02, 08/04/03, 01/01/08
The purpose of this rule is to explain the requirements of healthchek, Ohio's early and periodic screening, diagnostic and treatment (EPSDT) Medicaid benefit for all recipients under twenty-one years of age. A separate healthchek application is not required. All Medicaid recipients under twenty-one years of age are entitled to all healthchek services that are medically necessary services.

Definitions. For the purposes of this rule, the following terms have the following meanings:

1. "CDJFS" means county department of job and family services.
3. "Healthchek" is Ohio's early and periodic screening, diagnostic and treatment benefit for all recipients under twenty-one years of age.
4. "Healthchek coordinator" is the staff person or primary liaison within a unit in the CDJFS who is responsible for the implementation of EPSDT/healthchek services.
5. "Healthchek services" are periodic screening services (including a comprehensive medical exam, vision, dental, and hearing screenings) and such other necessary health care, diagnostic services, treatment, and other measures described in 42 U.S.C. section 1396d(a) (eff. 1/1/2011) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan. Healthchek services are identical to "EPSDT services" as defined at 42 U.S.C. section 1396d(r).
6. "Healthchek Services Implementation Plan" (HSIP) means the document submitted by a CDJFS describing how it delivers healthchek services to recipients in its county and who in the agency is responsible for ensuring the delivery of healthchek services.
7. "Managed care plan" (MCP) means a Medicaid managed care plan as defined in Chapter 5101:3-26 of the Administrative Code.
8. "Medically necessary services" has the same meaning as in rule 5101:3-1-01 of the Administrative Code.
9. "Prior authorization" for a member of a Medicaid MCP is the process outlined in Chapter 5101:3-26 of the Administrative Code. For all other recipients, prior authorization is the process outlined in Chapter 5101:3-1 of the Administrative Code.
10. "Private child placing agency" (PCPA) has the same meaning as in Chapter 5101:2-1 of the Administrative Code.
11. "Private non-custodial agency" (PNA) has the same meaning as defined in Chapter 5101:2-1 of the Administrative Code.
12. "Provider" means "eligible provider" as defined in Chapter 5101:3-1 of the Administrative Code.
13. "Public children services agency" (PCS) has the same meaning as in Chapter 5101:2-1 of the Administrative Code.
14. "Recipient" means an Ohio Medicaid recipient under twenty-one years of age.
15. "Special populations" means recipients who are blind or deaf or who cannot read or understand the English language.
Informing. County departments of job and family services are responsible for informing recipients in their counties about healthchek. Each CDJFS shall use a combination of written and oral (including telephone calls, office visits, or home visits) methods to effectively inform recipients (or such recipients' parents, guardians or legal custodians, as applicable) in its county about healthchek within sixty days of the eligibility determination and at least once each year thereafter. Appropriate oral and written informing methods are described below.

(1) Written informing.

(a) Each CDJFS shall ensure that each recipient (or such recipient's parent, guardian or legal custodian, as applicable) in its county receives JFS 03528 "Healthchek and Pregnancy Related Services Information" (rev. 2/2011) and JFS 08009 "Healthchek - Ohio's EPSDT Services Brochure" (rev. 11/2007) within sixty days after the recipient is determined eligible for medicaid and at least once each year thereafter:

(b) Each CDJFS shall document that each recipient (or such recipient's parent, guardian or legal custodian, as applicable) in its county has received a JFS 03528 and JFS 08009.

(c) If written healthchek information is sent to a recipient (or such recipient's parent, guardian or legal custodian, as applicable) and returned as undeliverable, the CDJFS will make a second attempt to contact the recipient by alternate means. All attempts to contact a recipient (or such recipient's parent, guardian, or legal custodian, as applicable) shall be documented.

(d) Upon the completion of the JFS 03528, the recipient (or such recipient's parent, guardian or legal custodian, as applicable) will be asked to sign the JFS 03528 form to verify understanding of the healthchek services available to the recipient. If the recipient (or such recipient's parent, guardian or legal custodian, as applicable) needs additional information in order to understand healthchek services, the CDJFS shall immediately provide the necessary information.

(e) Each CDJFS shall enter data regarding recipients into electronic information systems, as directed by ODJFS. Such information shall include information from completed JFS 03528 forms.

(f) Each CDJFS shall prominently post JFS 08137 "Healthchek Screenings, Diagnosis, Treatment" (rev. 9/2010) in an area where medicaid applications are accepted and where it can be seen by the maximum number of applicants and recipients.

(g) ODJFS may develop additional written materials containing information about healthchek. Each CDJFS shall distribute such written materials, as directed by ODJFS. All written materials that a CDJFS uses to inform individuals about healthchek shall be submitted to ODJFS for its review and approval. No CDJFS shall use such written materials unless they have been approved by ODJFS.

(h) Each CDJFS shall utilize ODJFS' information systems to monitor the quality of data regarding recipients, monitor the CDJFS' healthchek informing activities, and aid the CDJFS' healthchek informing activities.

(2) Oral informing. Each CDJFS shall ensure that each recipient (or such recipients' parents, guardians, or legal custodians, as applicable), who has a face-to-face meeting or telephone call with CDJFS staff to apply for medicaid, is orally informed about healthchek. The oral informing
shall include written informing material distributed to each CDJFS by ODJFS and shall include clear and non-technical language about the following:

(a) The benefits of preventive health care, including without limitation:
   (i) Increased well-being;
   (ii) Reduced risk to the recipient's health;
   (iii) Identification and treatment of health problems early to reduce the possibility of increase in their severity and cost of treatment; and
   (iv) Education of the family to allow for optimal health.

(b) The services covered by healthchek and where and how to obtain those services.

(c) That the services covered by healthchek are without cost to recipients.

(d) The recipient's ability to request and schedule dental, vision, and hearing services separately from the healthchek screening visit.

(e) The availability of medically necessary diagnostic and follow-up treatment services, including referrals, for problems discovered during the healthchek screening service.

(f) The prior authorization process, including that:
   (i) The prior authorization process, whether fee-for-service or managed care, must be started by the recipient's medicaid provider;
   (ii) The prior authorization requirement for some services, products, or procedures applies even if the recipient is under twenty-one years of age;
   (iii) The prior authorization process may enable individuals under twenty-one years of age to receive services not available to adults, including services that are limited in number for adults;
   (iv) Certain services require prior authorization, which must be requested by a provider and approved by Ohio medicaid before the service is provided; and
   (v) The provider of a recipient who is a member of an MCP must submit a prior authorization request to the recipient’s MCP.

(g) The CDJFS must explain necessary transportation and scheduling assistance is available to recipients under twenty-one years of age, upon request, in accordance with Chapter 5101:3-15, and the following:
   (i) That transportation will be provided to any medicaid reimbursable service;
   (ii) How to request transportation and the timeframes for requesting transportation;
   (iii) Verification requirements, if any; and
   (iv) That for a recipient who is a member of an MCP, transportation is also available through the recipient’s MCP.

(3) Informing special populations. Each CDJFS shall use appropriate methods to inform recipients in a special population (or such recipients' parents, guardians, or legal custodians, as applicable) about healthchek. Information provided to special populations shall meet the requirements of paragraphs (C)(2)(a) to (C)(2)(g) of this rule.

(4) Informing pregnant women. A JFS 03528 shall be used to document the informing of pregnant women about healthchek services as outlined in Chapter 5101:1-38 of the Administrative Code. The JFS 03528 shall be used to document informing again upon the birth of the infant.

(5) The CDJFS shall use electronic means to track pregnant women and the births of their infants to accomplish the following:
(a) Identify newborns and the infant’s parent, guardian, legal custodian, as applicable, or the PCSA, using the CDJFS' existing records.

(b) Ensure that any infant is added to the assistance group (AG) within thirty days of learning of the birth of the infant;

(c) Inform the infant’s parent, guardian, legal custodian, as applicable, of healthchek services within sixty days of the infant's birth;

(d) Contact the infant's parent, guardian, legal custodian, as applicable, to assist in securing an ongoing primary care provider for the newborn;

(e) Coordinate the activity in paragraphs (C)(1) to (C)(3) of this rule with the assistance group's MCP, other agencies, and programs where applicable.

(D) Provision of support services.

(1) The CDJFS will refer the recipient, and/or the recipient's parent, guardian, or legal custodian, as applicable, to entities listed on the JFS 03528 and/or other community services as requested. The CDJFS will ensure:

(a) That referrals are made, as needed, for both medical and other services such as help me grow (HMG); women, infants and children (WIC); maternal and child health clinics; local health departments; head start (HS); child care; clothing and/or other community social services, where applicable.

(b) Coordination between the recipient and the entity where the referral is made.

(c) Coordination between the recipient and the medical provider or MCP.

(d) The recipient enrolled in a MCP (or the recipient's parent, guardian or legal custodian, as applicable) is advised to contact the recipient's MCP for medical care options and/or referrals.

(e) Offering and providing assistance with scheduling medical appointments as requested by the recipient or the recipient's parent, guardian or legal custodian, as applicable.

(2) The CDJFS shall provide recipients with necessary assistance in obtaining transportation to healthchek services as requested by the recipient or the recipient's parent, guardian or legal custodian, as applicable.

(3) Each recipient in a household who requests or is in need of non-medicaid covered medical services as indicated on the JFS 03528 or through other verbal or written communication shall be referred by the CDJFS to community, medical or other social services, as needed, including providers who have expressed a willingness to furnish non-medicaid covered services at little or no expense to the family. Community and medical service requests will be documented and forwarded to the appropriate community provider, medical provider and/or MCP.

(4) Elevated blood lead level services for assisting families of recipients identified as having elevated blood lead levels when notified by the family, provider or the county or city department of health shall be provided by the CDJFS and include:

(a) Referral of the recipient to the Ohio department of health (ODH) for an environmental assessment.

(b) Verification of medicaid eligibility at the time the environmental assessment is conducted and informing the ODH agent of such eligibility, when asked and after receiving proper verification of whom, is requesting the information;

(c) Education of the family about the purpose of the environmental assessment by:

(i) Informing the family of the need to remove the source of lead or removing the recipient from the contaminated environment;

(ii) Explaining the family's responsibility to inform the health department staff who conduct the environmental assessment of places the recipient visits regularly;
(iii) Assisting the family with securing lead-free housing by making any necessary referrals if the source of lead cannot or will not be removed from the environment.

(d) The CDJFS is responsible for maintaining records of environmental assessment recommendations made by the ODH and any action taken as a result of those recommendations. If as a result of CDJFS efforts the family relocates, the CDJFS must inform the ODH of the family’s new address.

(e) In geographic areas with Ohio childhood lead poisoning prevention regional resource centers or local arrangements for environmental assessments and follow-up, the requirements of those programs supersede this rule.

(E) Custodial agency responsibility.

(1) The custodial agency of a recipient is responsible for ensuring that healthchek informing requirements are completed as explained in this rule. A custodial agency that has a recipient child placed in a substitute care setting certified by another PCSA, PCPA or PNA, is responsible for complying with this rule.

(2) The PCSA, PCPA and the Title IV-E agency shall inform the substitute caregivers about healthchek services and complete the JFS 03528.

(3) The JFS 03528 shall be submitted by the PSCA, PCPA, or Title IV-E agency to the CDJFS:

   (a) After the initial informing process;

   (b) When the recipient is moved to a new placement setting; and

   (c) After completion of each annual review.

(F) CDJFS healthchek service implementation plan. Each CDJFS shall submit a proposed HSIP to ODJFS within ten business days of a change in director, healthchek coordinator or where the responsibility for healthchek resides in the agency. The proposed HSIP shall include all of the following:

(1) Identification of the CDJFS table of organization, showing where the responsibility for delivery of administrative healthchek support services lies:

   (a) The name, title and contact information of the contact person or coordinator for administrative healthchek support services;

   (b) A job description of the staff responsible for administration of administrative healthchek support services.

(2) Procedures for coordination of efforts between the CDJFS and the MCPs. The procedures may be in the form of written agreements between the agency and the MCPs and shall include:

   (a) Provisions for regularly scheduled meetings to exchange information regarding:

      (i) Tracking recipients to ensure they are receiving care and other services as identified as needed;

      (ii) Issues recipients may be having in accessing services (such as finding a provider, making appointments, accessing transportation) and identifying remedies to these issues;

      (iii) Social support services needed or discovered for recipients (such as housing needs, clothing, increased food needs);

      (iv) MCP referrals to other agencies (such as HMG, WIC, and HS) so the healthchek coordinator can follow-up with the family; and

      (v) The JFS 03528 or other documentation.

   (b) A method for MCPs and the CDJFS to share follow-up and other communication with the recipient (or such recipient's parent, guardian or legal custodian, as applicable) to ensure complete care is delivered.
(3) The CDJFS shall provide a description in the HSIP of the electronic and/or hard-copy methods for ensuring permanent records and documentation are maintained in a case file for each recipient. The case file shall contain the following information, when appropriate:

(a) The agency copy of the signed JFS 03528;
(b) Copies of all correspondence received and sent;
(c) Documentation of agency contacts with recipients (or such recipient's parent, guardian or legal custodian, as applicable), both attempted and successful;
(d) Documentation of the MCP in which recipients are enrolled, if applicable;
(e) Any communication from or forms provided by the medical provider;
(f) Information received from the other county when a recipient is an inter-county transfer;
(g) Documentation of all support service referrals or requests made by a recipient or on a recipient's behalf, and the CDJFS efforts to fulfill the referrals and/or requests. At a minimum the documentation shall contain:

(i) Steps taken by the CDJFS to assure the requested support services are provided, and whether or not the recipient received the requested support services;
(ii) A copy of all documentation of services requested by a recipient (or such recipient's parents, caretakers, custodians or substitute caregivers, as applicable) and provided or facilitated by the CDJFS.
(iii) Records of transportation requested and provided; and
(iv) Any communication from or forms provided by the medical provider.

(4) The CDJFS shall identify, if applicable, any services or functions required in this rule which are contracted out to other entities. A copy of the contract shall be provided to ODJFS. The CDJFS shall also describe accountability and monitoring measures, along with timeframes when monitoring takes place to ensure the contracted entities are achieving all required functions and that these functions are in accordance with applicable state and federal rules.

(G) Release of information. The CDJFS shall, if necessary, obtain a HIPAA-compliant signed authorization for release of information, form JFS 03397 "Authorization for the Release or Use of Protected Health Information (PHI)" (rev. 7/2003), if and when the CDJFS needs additional medical information from the recipient or the recipient's provider.

(H) Provider recruitment. The CDJFS is required to take steps to recruit and maintain a network of fee-for-service providers of medical, dental, vision, and hearing services that is adequate to meet the screening and treatment needs of the healthcheck consumers. The CDJFS may make use of a variety of methods including personal visits, telephone calls, and letters to recruit providers.

(I) Training. Each CDJFS' healthcheck coordinator, or such coordinator's designee(s), shall attend annual training and attend any other available healthcheck training offered by ODJFS. Recording a training for later viewing does not constitute attendance. Verification of attendance shall consist of documentation roll call and sending an evaluation form to the state e-mail box within three days of the video conference or training for video conferences. Verification of attendance at an on site training shall be documented by the healthcheck coordinator or such coordinators' designee(s) by signing the attendance log.

(J) Responsibilities of recipient. A recipient (or the recipient's parent(s), guardian or legal custodian, as applicable) shall:

(1) Complete the JFS 03528;
(2) Return the JFS 03528 to the recipient's healthcheck coordinator as soon as it is completed;
(3) As soon as possible, report to the recipient's CDJFS any change in a recipient's address or family or household group; and
(4) Attend scheduled appointments for healthcheck services.

Replaces: 5101:1-38-05
Effective: 02/14/2011
R.C. 119.032 review dates: 11/01/2015
Certification: CERTIFIED ELECTRONICALLY
Date: 02/04/2011
Promulgated Under: 111.15
Statutory Authority: 5111.01
Rule Amplifies: 5111.01, 5111.016
Prior Effective Dates: 12/24/79, 7/1/88, 5/1/92, 5/1/93, 1/1/94, 10/1/98, 5/1/02, 10/6/03, 10/15/05
MEMTL 96

Effective Date: January 1, 2015

(A) The purpose of this rule is to outline the responsibilities of the administrative agency to inform medicaid-eligible pregnant women about the benefits and importance of pregnancy related services (PRS), to make requested or needed referrals to support services, and to provide non-medical services promoting healthy birth outcomes in accordance with 42 C.F.R. 440.210 (as in effect January 1, 2014).

(B) Definitions.

(1) "Individual" for the purpose of this rule, means a medicaid-eligible individual who is pregnant, as verified by either self-declaration or medical verification, including the sixty days post-partum period.

(2) ODM 03515 "Pregnancy Related Services Implementation Plan" (PRSIP) (rev. 1/2015) means the document submitted by an administrative agency describing how it delivers PRS to pregnant women in its county and which entity is responsible for ensuring the delivery of PRS.

(3) "PRS coordinator" means the administrative agency employee who is responsible for the implementation of PRS.

(4) "Support services" are non-medical services offered or provided by the administrative agency to assist the individual and may include arranging or providing transportation, making medical appointments, accompanying the individual to medical appointments, and making referrals to community and other social services. Support services will be coordinated with the individual's medicaid-contracting managed care plan (MCP), where applicable.

(C) The individual (or the individual's parent(s), guardian or legal custodian, as applicable) may:

(1) Complete and sign the ODM 03528, "Healthchek and Pregnancy Related Services Information Sheet" (rev. 7/2014) to verify understanding of PRS and Healthchek services;

(2) Complete, sign, and return the ODM 03528 to identify her own and her children's need for services.

(D) Administrative agency responsibilities. The administrative agency shall:

(1) Inform individuals in its county about PRS within sixty days of the eligibility determination. Informing methods shall be written, oral or a combination of written and oral methods, as described below:

(a) Provide the ODM 03528, "Healthchek and Pregnancy Related Services Information Sheet" (rev. 7/2014).

(b) Provide information about:

(i) The benefits and importance of early and continual prenatal and postpartum care.

(ii) The services covered by PRS as described in Chapter 5160-4 of the Administrative Code.

(iii) The benefits of healthchek services as described in 5160:1-2-05 of the Administrative Code.

(iv) Transportation services and scheduling assistance available to individuals, if needed and upon request, in accordance with Chapter 5160-15 of the Administrative Code.

(v) Availability of transportation services through the individual's MCP. The transportation services shall be provided by the administrative agency if not available from the MCP.
(vi) Transportation services and scheduling assistance available to infants during the first year of life.

(vii) Medical and non-medical support services to include but not limited to:

(a) "The Help Me Grow" (HMG) program;
(b) The special supplemental food program for women, infants and children (WIC);
(c) Maternal and child health clinics;
(d) Local health departments;
(e) Social services and other community services.

(viii) Availability of assistance for scheduling medical appointments, as requested by the individual.

(ix) A list of medicaid prenatal care providers, if requested, available to the community and/or information about medicaid-contracting MCPs.

(2) Inform individuals enrolled in a MCP that they should contact the MCP for medical care options and referrals.

(3) Re-inform the individual of the benefits of healthchek services as soon as possible after the infant's birth.

(4) Refer the individual to support services as requested verbally, in writing, or via the ODM 03528 and ensure:

(a) Referrals are made, as needed, for medical and non-medical support services.
(b) Coordination between the individual, medical provider, MCP or other entity where the referral is made.
(c) Transportation assistance is provided to individuals, as requested.
(d) Individuals in need of non-medicaid covered medical services are referred to community, medical or other social services. This includes providers who have expressed a willingness to furnish non-medicaid covered services at little or no expense to the individual.

(5) Establish contact with the individual upon notification from the medical provider or MCP that the individual has missed appointments or there are other problems in the delivery of care and inform the individual's medical provider or MCP about the outcome of the contact.

(6) Provide a copy of the ODM 03528 (if applicable) and the ODM 03535 "Prenatal Risk Assessment Form" (if applicable) (rev. 7/2014) to the individual's MCP.

(7) Make a second attempt to contact the individual by alternate means if written information about PRS sent to the individual is returned as undeliverable.

(8) Submit a new or amended ODM 03515 "Pregnancy Related Services Implementation Plan" (rev. 1/2015) to Ohio department of medicaid (ODM), including but not limited to, when there has been a change of agency address, director, PRS coordinator or where the responsibility for PRS is organizationally located within the agency. The ODM 03515 shall be submitted to ODM within ten business days of the change.

(9) Obtain a HIPAA compliant signed authorization for release of information, ODM 03397 "Authorization for the Release or Use of Protected Health Information (PHI) or Other Confidential Information" (rev. 8/2014), when additional medical information is needed from the individual.

(10) Maintain a listing of fee-for-service providers who have expressed a willingness to furnish non-medicaid covered services at little or no expense to the individual. It is recognized that the ability...
of the administrative agency to recruit and maintain an adequate provider network depends on the existence of appropriate providers within a reasonable geographic area.

(11) Maintain documentation in a case file for each eligible individual. The file shall consist of permanent records, either hard copy or electronically stored, containing the following information, when appropriate:

(a) Copy of the ODM 03528, ODM 03535, or other referral forms received by the county;
(b) Copy of correspondence received and sent;
(c) Documentation of agency contacts with the individual, both attempted and established;
(d) Documentation of the MCP in which the individual is enrolled;
(e) Information received from another county when the individual is an intercounty transfer;
(f) Documentation of all service requests, steps taken by the administrative agency, and whether the individual received services; and
(g) Records of transportation services provided.

(E) Each administrative agency PRS coordinator, or such coordinator's designee(s), shall attend annual and other pertinent trainings offered by ODM. Verification of attendance shall consist of documentation of roll call and sending an evaluation form to the state email box within three days of the video conference or training. Verification of attendance at onsite training shall be documented by the PRS coordinator or such coordinator's designee(s) by signing the attendance log.

Replaces: 5160:1-2-06
Effective: 01/15/2015
Five Year Review (FYR) Dates: 01/15/2020
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MEMTL 101

Effective Date: March 23, 2015

(A) This rule describes breast and cervical cancer project medicaid.

(B) The rules in Chapter 5160:1-5 of the Administrative Code set forth the eligibility requirements for participation in the breast and cervical cancer project. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA), in accordance with Pub. L. No. 106-354 and 42 U.S.C. 1396a(a)(10)(A)(ii) (as in effect on September 1, 2014), authorizes an optional category of medicaid to provide full medicaid benefits to certain individuals who need treatment for breast or cervical cancer, breast or cervical pre-cancerous conditions, and/or breast or cervical early stage cancer. The goals of the BCCPTA are as follows:

(1) To improve access to needed breast and cervical cancer treatment for uninsured individuals identified under the national breast and cervical cancer early detection program as needing such treatment;

(2) To facilitate the prompt enrollment in medicaid and immediate access to services for individuals who are in need of treatment for breast or cervical cancer;

(3) To ensure that needed treatment begins as early as possible; and

(4) To coordinate activities between medicaid and public health agencies, including but not limited to application procedures and case management.

Replaces: 5160:1-5-01

Effective: 03/23/2015

Five Year Review (FYR) Dates: 03/23/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/13/2015

Promulgated Under: 111.15

Statutory Authority: 5160.02, 5163.02

Rule Amplifies: 5160.02, 5163.02

Prior Effective Dates: 7/1/02
MEMTL 101

Effective Date: March 23, 2015

(A) This rule contains definitions generally used for BCCP.

(B) Definitions.

(1) "Breast and Cervical Cancer Project (BCCP) medicaid" means the category of medicaid for qualified individuals in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. BCCP medicaid is administered by the Ohio department of medicaid (ODM) in coordination with the Ohio department of health (ODH).

(2) "Breast or cervical cancer diagnosis", for the purpose of BCCP medicaid, means that a treating health professional has made a general determination that breast or cervical cancer(s) or pre-cancerous condition(s) exists. For the purposes of BCCP medicaid, breast or cervical cancer diagnosis does not require the determination of the specific stage or grade of cancer or pre-cancerous conditions.

(a) "Breast or cervical cancer diagnosis" includes metastasized cancer known or presumed by a treating health professional as a complication of breast or cervical cancer.

(b) "Date of diagnosis" is the date of the screening or diagnostic service which the treating health professional utilized to determine the individual's breast or cervical cancer diagnosis.

(c) "Pre-cancerous" means a condition, which, if left untreated is known or presumed by a treating health professional to develop into cancer.

(3) "Centers for Disease Control and Prevention (CDC) Title XV grantee" means an entity receiving funds under a cooperative agreement with CDC to support activities related to the national breast and cervical cancer early detection program.

(4) "Individual", for the purpose of BCCP medicaid, means men or women in need of or receiving treatment for breast or cervical cancer, breast or cervical pre-cancerous conditions, and/or breast or cervical early stage cancer or eligible for BCCP medicaid.

(5) "The National Breast and Cervical Cancer Early Detection Program (NBCCEDP)" means the program of the CDC established under Title XV of the Public Health Service Act.

(6) "The Ohio Department of Health Breast and Cervical Cancer Project (ODH BCCP)" means NBCCEDP funded by the CDC and administered by the Ohio department of health (ODH).

(a) "ODH BCCP breast and cervical cancer screening provider" means an entity which has entered into a written agreement with the ODH BCCP to provide specified breast and cervical cancer screening and diagnostic services for ODH BCCP enrollees.

(b) "ODH BCCP designated local agency or subgrantee" means an entity which has received a grant from ODH to implement specified activities of the ODH BCCP.

(c) "ODH BCCP enrollee" means an individual determined by ODH BCCP, or its designated local agencies or subgrantees, to meet the eligibility requirements (e.g., age and income) for participation in the ODH BCCP.

(d) "ODH BCCP regional case manager" means an individual who determines an individual's eligibility for BCCP, enrolls individuals, schedules services with health care providers, and provides case management to individuals.

(7) "Screened for breast or cervical cancer under NBCCEDP" means that a breast or cervical cancer screening was provided, all or in part, by CDC Title XV funds.

(a) For the purposes of BCCP medicaid, breast or cervical cancer screening includes diagnostic test(s) following a breast or cervical cancer screen.
For the purposes of BCCP medicaid, case management services provided by a CDC Title XV grantee are not considered breast or cervical cancer screening.

"Treatment" means the provision of medical services to control, minimize, or eliminate cancer or pre-cancerous cells of the breast or cervix. "Treatment" includes the provision of hormonal therapies to prevent recurrence of cancer following breast cancer surgery, radiation, and/or chemotherapy. Monitoring services alone (e.g., Papanicolaou smears, pelvic examinations, clinical breast examinations, mammograms) for recurrence or new primary cancers are not considered treatment.

"Needs treatment" means that according to a written certification by the individual's treating health professional, which is documented by the ODH BCCP, a breast or cervical cancer screening indicates that the individual is in need of treatment for breast or cervical cancer. Individuals who are determined to require only monitoring services (e.g., Papanicolaou smears, pelvic examinations, clinical breast examinations, mammograms) are not considered to need treatment.

"No longer receives treatment for breast or cervical cancer" means:
(i) The individual's course of treatment of breast or cervical cancer is completed, or
(ii) The individual chooses to delay or decline available treatment options.

"Treating health professional" means an individual licensed to provide breast or cervical cancer diagnosis and/or treatment services.

"Treatment period" means the period of time, according to a written certification by the individual's treating health professional, needed for the completion of treatment of the individual's breast or cervical cancer or pre-cancerous condition. A treatment period lasting more than twelve months from initial eligibility requires both a review of continuing medicaid eligibility and verification of need for continued treatment.

"Uninsured" means not having creditable coverage for health care services.

For the purposes of determining eligibility under BCCP medicaid, the following are considered creditable coverage unless one of the exceptions in paragraph (B)(8)(b) of this rule is applicable:
(i) Health insurance benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract;
(ii) Health maintenance organization contract offered by a health insurance issuer;
(iii) Medicare, parts A and B; and,
(iv) Medicaid.

For the purposes of determining eligibility under BCCP medicaid, creditable coverage does not include:
(i) Limited scope coverage such as those which only cover dental, vision, or long term care;
(ii) Coverage for only a specified disease or illness;
(iii) Coverage which excludes treatment for breast or cervical cancer, including situations whereby a period of exclusion has been applied, such as for a pre-existing condition or the individual has exhausted the health insurance plan's covered benefits;
(iv) Delayed spenddown eligibility under the spenddown process provided in rule 5160:1-3-04.1 of the Administrative Code;
(v) Medicare part A only or medicare part B only.
Replaces: 5160:1-5-02
Effective: 03/23/2015
Five Year Review (FYR) Dates: 03/23/2020
Certification: CERTIFIED ELECTRONICALLY
Date: 03/13/2015
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02
Prior Effective Dates: 7/1/02
MEMTL 101

Effective Date: March 23, 2015

(A) This rule describes the eligibility criteria for BCCP medicaid.

(B) An individual shall meet all of the following criteria to be eligible for BCCP medicaid:

1. Be screened for breast or cervical cancer under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).
   a. An individual is not required to obtain screening for both breast and cervical cancer as a condition of eligibility for participation in the NBCCEDCP.
   b. Individuals screened for breast or cervical cancer under the NBCCEDP in a state other than Ohio must be determined eligible for the ODH BCCP and must utilize the ODH BCCP case management services and Ohio’s BCCP medicaid application process as outlined in rule 5160:1-5-02.4 of the Administrative Code.

2. Be uninsured as defined in rule 5160:1-5-02.1 of the Administrative Code.

3. Must not meet the eligibility criteria of any other medicaid program.

4. Be under sixty-five years of age.


(C) There are no income or resource limitations for BCCP medicaid.

(D) The CDC NBCCEDP funded screening shall indicate to a treating health professional that the individual needs treatment for breast or cervical cancer, pre-cancerous conditions, or early stage cancer.

(E) The Ohio department of health (ODH) or its designated local agencies or subgrantees shall:

1. Determine the individual eligible for the ODH BCCP.

2. Screen for all other medicaid programs before determining the individual eligible for ODH BCCP.

(F) The Ohio department of medicaid (ODM) shall:

1. Screen all BCCP medicaid applicants for potential eligibility in other medicaid programs as described in rule 5160:1-5-02.4 of the Administrative Code.

2. Require BCCP medicaid applicants to provide information regarding income and/or resources to screen the applicant for potential eligibility in other medicaid programs.

(G) Individuals not meeting citizenship or immigration status eligibility requirements may be eligible for coverage for an emergency medical condition as described in rule 5160:1-1-91 of the Administrative Code.

Replaces: 5160:1-5-03

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MEMTL 101

**Effective Date: March 23, 2015**

(A) This rule describes the eligibility period for breast and cervical cancer project medicaid.

(B) Effective date of BCCP medicaid.

(1) Eligibility for BCCP medicaid is effective the first day of the month that the Ohio department of medicaid (ODM) receives an application for this medicaid category and the applicant meets all relevant eligibility requirements described in rule 5160:1-5-02.2 of the Administrative Code.

(2) BCCP medicaid shall not cover an expense for a medical service incurred outside the eligibility period unless the individual is eligible for retroactive eligibility described in paragraph (D)(3) of this rule.

(3) The first month of BCCP medicaid coverage may be a partial month of coverage.

(C) BCCP medicaid shall be terminated:

(1) If the individual no longer meets one or more of the eligibility criteria for BCCP medicaid identified in rule 5160:1-5-02.2 of the Administrative Code.

(2) If a finding is made that the individual was determined eligible for Ohio department of health (ODH) BCCP when such determination was made in error and ODH BCCP eligibility did not exist.

(3) If a finding is made that the individual was not screened for breast or cervical cancer under NBCCEDP.

(4) If the individual no longer receives treatment for breast or cervical cancer, pre-cancerous conditions, or early stage cancer. "Treatment" and "no longer receives treatment of breast or cervical cancer" are defined in rule 5160:1-5-02.1 of the Administrative Code.

(5) If the treatment period has ended and required redetermination documents with verification of continued need for treatment has not been received by ODM.

(a) ODM may presume that an individual is receiving treatment for the duration of the treatment period.

(b) A treatment period lasting more than twelve months from the beginning month of BCCP eligibility requires the ODM to perform a review of the individual's continuing medicaid eligibility, in accordance with rule 5160:1-5-02.4 of the Administrative Code.

(6) If the individual obtains creditable health coverage as defined in rule 5160:1-5-02.1 of the Administrative Code.

(7) If the individual reaches sixty-five years of age.

(8) If the individual meets eligibility criteria of any other category of medicaid, except as described in rule 5160:1-5-02.1 (B)(8)(b) of the Administrative Code. If the individual is determined eligible for any other category of medicaid, the last day of BCCP medicaid coverage will be the last day of the month prior to the month the new category of medicaid begins.

(9) If the individual fails to cooperate in the eligibility determination process, including the determination of eligibility for other categories of medicaid.

(a) To facilitate immediate access to services for individuals who are in need of treatment for breast or cervical cancer, BCCP medicaid coverage will be allowed for a period of time while an eligibility determination for other categories of medicaid is conducted.

(b) If the individual fails to cooperate in the determination of eligibility for other categories of medicaid as required, the last day of BCCP medicaid coverage will be the last day of the
(10) If the individual no longer meets other non-financial and non-resource eligibility requirements applicable to medicaid as described in rule 5160:1-5-02.2 (B)(6) of the Administrative Code.

(D) Ohio department of medicaid (ODM) responsibilities. ODM shall:

(1) Not provide BCCP medicaid coverage, including retroactive coverage, for any period of time preceding the individual's fortieth birthday or following the individual's sixty-fifth birthday.

(2) Not provide BCCP medicaid coverage, including retroactive coverage, for any period of time preceding the date of diagnosis of breast or cervical cancer, pre-cancerous conditions, or early stage cancer. "Date of diagnosis" is defined in rule 5160:1-5-02.1 of the Administrative Code.

(3) Extend eligibility for BCCP medicaid retroactively to the third month prior to the month of application if the individual met all relevant eligibility requirements described in rule 5160:1-5-02.2 of the Administrative Code for each of the three months in which retroactive coverage is sought.

Replaces: 5160:1-5-04
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Prior Effective Dates: 7/1/02
This rule describes the application and redetermination process for the breast and cervical cancer project (BCCP).

The BCCP Medicaid application and redetermination process shall:

1. Be coordinated between Ohio Department of Medicaid (ODM), Ohio Department of Health (ODH) BCCP, and ODH BCCP designated local agencies and/or subgrantees,
2. Be coordinated with ODH BCCP case management services, and

ODH BCCP and its designated local agencies or subgrantee responsibilities. The ODH BCCP and its designated local agencies or subgrantee shall:

1. Provide the ODM 07161 "Ohio Breast and Cervical Cancer Project (BCCP) Medicaid Application" (rev. 7/2014) to ODH BCCP enrollees screened for breast or cervical cancer under the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program (NBCCEDP) and referred for breast or cervical cancer diagnostic evaluation.
2. Provide the ODM 07161 to ODH BCCP enrollees screened for breast or cervical cancer under the CDC NBCCEDP who are receiving treatment for breast or cervical cancer, pre-cancerous conditions, or early stage cancer.
3. Notify in writing ODH BCCP enrollees described in paragraph (C)(1) and (C)(2) of this rule to return the completed ODM 07161 to the designated ODH BCCP regional case manager.

ODH BCCP regional case manager responsibilities.

1. The application process. The ODH BCCP regional case manager shall:
   a. Provide to ODM the completed ODM 07161 within five business days of receipt of the diagnostic information if:
      i. The ODH BCCP enrollee has submitted the ODM 07161; and
      ii. The ODH BCCP screening provider notifies the designated ODH BCCP regional case manager that, as a result of the NBCCEDP funded screening, a treating health professional has determined the ODH BCCP enrollee needs treatment for breast or cervical cancer, pre-cancerous conditions, or early stage cancer.
   b. Notify the ODH BCCP enrollee in writing within five business days of the receipt of the diagnostic information, that the ODM 07161 must be submitted to the designated ODH BCCP regional manager if:
      i. The enrollee has not submitted the ODM 07161; and
      ii. The ODH BCCP screening provider notifies the designated ODH BCCP regional case manager that, as a result of the NBCCEDP funded screening, a treating health professional has determined the ODH BCCP enrollee needs treatment for breast or cervical cancer, pre-cancerous conditions, or early stage cancer.
   c. Notify the ODH BCCP enrollee in writing within five business days that the ODM 07161 will not be submitted to ODM if:
      i. The ODH BCCP enrollee submits the ODM 07161; and
The diagnostic results indicate that the ODH BCCP enrollee does not need treatment for either breast or cervical cancer, pre-cancerous conditions, or early stage cancer.

(2) The redetermination process. The ODH BCCP regional case manager shall:

(a) Provide to ODM the completed ODM 07160 "Healthcare Provider’s Revision of Treatment Plan" (7/2014) and ODM 07161 within five business days of receipt of both documents and notification from the treating health professional if:

(i) The individual submitted the ODM 07160 and ODM 07161; and

(ii) The treating health professional notifies the designated ODH BCCP regional case manager that the individual has been found to need continued treatment for either breast or cervical cancer, pre-cancerous conditions, or early stage cancer.

(b) Notify the individual in writing within five business days of receipt of the diagnostic information, that the ODM 07160 and ODM 07161 must be submitted to the designated ODH BCCP case manager for continued BCCP medicaid eligibility if:

(i) The individual has not submitted the ODM 07160 and ODM 07161; and

(ii) The treating health professional notifies the designated ODH BCCP regional case manager that the individual has been found to need continued treatment for either breast or cervical cancer, pre-cancerous conditions, or early stage cancer.

(c) Notify the individual in writing within five business days that the ODM 07160 and ODM 07161 will not be submitted to ODM if:

(i) The individual submitted the ODM 07160 and ODM 07161; and

(ii) The treating health professional notifies the designated ODH BCCP case manager the individual has been found to not need continued treatment for either breast or cervical cancer, pre-cancerous conditions, or early stage cancer.

(E) ODM responsibilities. ODM shall:

(1) Make available to the ODH BCCP and its designated local agencies or subgrantees the ODM 07161 and the ODM 07160.

(2) Be responsible for all determinations of BCCP medicaid eligibility, including retroactive eligibility.

(3) Use available sources of information in the eligibility determination including:

(a) Information contained in the ODM 07160 and ODM 07161; and

(b) Information in the case record to determine if the individual is currently enrolled in medicaid or has pending medicaid application.

(4) Use the eligibility criteria set forth in rules 5160:1-5-02.2 and 5160:1-5-02.3 of the Administrative Code.

(5) Complete all determinations of eligibility within forty-five days of receipt of a completed ODM 07161.

(a) A delay in the determination of redetermination shall not be a basis for granting eligibility; or

(b) An application pending beyond forty-five days shall not be the sole basis for denial.

(6) Redetermine BCCP medicaid eligibility either:

(a) Prior to the completion of the lesser of:

(i) The individual's treatment period; or

(ii) Twelve months continuous eligibility in BCCP medicaid.
When ODM receives an ODM 07160 indicating a change in the individual’s circumstances, including completion of treatment prior to the original determined treatment period.

Provide written notice to the BCCP medicaid recipient:

(a) That information is required for the determination of BCCP medicaid eligibility, and
(b) To return required completed redetermination materials to the assigned ODH BCCP regional case manager.

Individual responsibilities. The individual shall:

(1) Submit a completed ODM 07160 (if applicable) and ODM 07161 to the designated ODH BCCP regional case manager.

BCCP medicaid is terminated when the individual:

(1) Fails to submit the ODM 07160 and ODM 07161 by the required deadline, or
(2) No longer meets the eligibility criteria for continued BCCP medicaid and is ineligible for any other medicaid program.

An individual may apply for a new period of BCCP medicaid eligibility after BCCP medicaid termination.

(1) A period of BCCP medicaid eligibility shall begin each time an individual:

(a) Is screened for breast or cervical cancer under the CDC NBCCEDP, and
(b) Is found, as a result of the CDC NBCCEDP screening, to need treatment of breast or cervical cancer, pre-cancerous condition, or early stage cancer, and
(c) Submits a completed ODM 07161 in accordance with paragraph (F) of this rule, and
(d) Is determined by ODM to meet all eligibility criteria for BCCP medicaid as described in rule 5160:1-5-02.2 of the Administrative Code.

(2) Individuals who have completed a treatment period, have had their BCCP medicaid eligibility terminated, and subsequently have been found to have new, recurrent, or metasticized breast or cervical cancer, pre-cancerous condition, or early stage cancer shall meet the BCCP medicaid eligibility requirements defined in rule 5160:1-5-02.2 of the Administrative Code to be determined eligible for an additional period of BCCP medicaid coverage.

(3) Individuals who have not completed their treatment period, have had their BCCP medicaid eligibility terminated, and have been found to have new, recurrent, or metasticized breast or cervical cancer:

(a) Do not need to be recertified as eligible for the ODH BCCP to reestablish BCCP medicaid eligibility; and
(b) Shall submit a new ODM 07161 to reestablish BCCP medicaid eligibility.

Screening for potential eligibility for other medicaid programs by ODM at application and redetermination.

(1) If information on the ODM 07161 indicates the individual is not potentially eligible for any other medicaid program, income and asset information is not needed and ODM shall notify the individual in writing of ineligibility for other medicaid programs.

(2) If information on the ODM 07161 indicates the individual is potentially eligible for any other medicaid program, the individual shall provide income and asset information to screen for eligibility for other medicaid programs.

(a) If income or asset information indicates the individual does not appear eligible for any other medicaid program, no additional income or asset information is needed and ODM shall notify the individual in writing of ineligibility for other medicaid programs.
(b) If income or asset information indicates the individual appears eligible for any other medicaid programs, the individual shall be:

(i) Notified of potential eligibility;

(ii) Given instructions for submission of additional information required to make a determination of eligibility for other medicaid programs.

(iii) Notified by ODM in writing to complete and submit additional information required to the CDJFS in the individual's county of residence.

(a) If the CDJFS determines the applicant eligible for any other category of medicaid, ODM will terminate BCCP medicaid and transfer the case information to the CDJFS in accordance with paragraph (C)(8) of rule 5160:1-5-02.3 of the Administrative Code.

(b) If the CDJFS determines the individual ineligible for any other medicaid program, the CDJFS will notify ODM and ODM will maintain the BCCP medicaid case.
MEMTL 101

Effective Date: March 23, 2015

(A) This rule governs the eligibility requirements for two medicaid programs authorized under sections 1902(a)(10)(A)(ii)(XV) and (XVI) of the Social Security Act (as in effect on September 1, 2014). Medicaid buy-in for workers with disabilities (MBIWD) enables certain individuals to increase their income and resources without the risk of losing health care coverage.

(B) Definitions.

1. "Basic covered group" means the medicaid covered group of individuals meeting all criteria in paragraph (C)(1) of this rule.

2. "Blind work expense (BWE)" has the same meaning as in rule 5160:1-3-03.11 of the Administrative Code.

3. "Countable income", for the purpose of this rule, means income less exclusions.

4. "Countable resources", for the purpose of this rule, means those resources remaining after all exclusions have been applied.

5. "Earned income", for the purpose of this rule, means salary, wages, royalties, honoraria, or "net earnings from self-employment" as defined in rule 5160:1-2-01.9 of the Administrative Code.

6. "Family", for the purpose of this rule, means an individual, the individual's spouse, and dependent children living in the household of the individual. If an individual is younger than eighteen years of age, "family" also means the individual's parents.

7. "Impairment-related work expense (IRWE)" as defined in 20 C.F.R. 404.1576 (as in effect on September 1, 2014).

8. "Income", for the purpose of this rule, means gross earned income and gross unearned income.

9. "Individual", for the purpose of this rule, means the applicant for or participant in MBIWD.

10. "Individual with a medically improved disability" means an individual who is participating in the MBIWD basic covered group at the time of a regularly scheduled continuing disability review, but who no longer meets the disability criterion as defined in paragraph (C)(1)(c) of this rule.

11. "Medicaid buy-in for workers with disabilities (MBIWD)" means the component of the medicaid program established under sections 5163.09 to 5163.099 of the Revised Code and includes the basic covered group and the medically improved covered group.

12. "Medical and remedial expense (MRE)" means an incurred expense for care, services, or goods prescribed or provided by a licensed medical practitioner within the scope of practice as defined under state law. This expense is the responsibility of the individual, and cannot be reimbursed by any other source, such as medicaid, private insurance, or an employer.

13. "Medical insurance premiums" has the same meaning as in rule 5160:1-3-04.1 of the Administrative Code.

14. "Medically improved covered group" means the individuals meeting all criteria in paragraph (C)(2) of this rule.

15. "Premium" means a periodic payment required under section 5163.094 of the Revised Code and described in paragraph (E) of this rule.

16. "Resource" means cash, personal property, and real property an individual has an ownership interest in and legal ability to access in order to convert to cash.

17. "Resource eligibility limit for MBIWD", means countable resources limited to the amount specified under section 5163.092 of the Revised Code.
(18) "Social security disability insurance (SSDI)" means the program established under Title II of the Social Security Act (as in effect on September 1, 2014).

(19) "Spouse" means a person legally married under Ohio law.

(20) "Supplemental security income program (SSI)" means the program established under Title XVI of the Social Security Act (as in effect on September 1, 2014).

(21) "Unearned income" means all income that is not earned income.

(22) "Work" or "working", for the purpose of this rule, means full or part-time employment or self-employment from which state or federal income and payroll taxes are paid or withheld.

(C) Eligibility criteria.

(1) To be eligible for the MBIWD basic covered group an individual must:
   (a) Meet the citizenship requirements outlined in rule 5160:1-1-58.2 of the Administrative Code;
   (b) Be a resident of Ohio as set forth in rule 5160:1-1-58 of the Administrative Code;
   (c) Meet the definition of disability used by the social security administration (SSA), except that employment, earnings, and substantial gainful activity must not be considered when determining whether the individual meets the disability criterion for MBIWD. An individual may be eligible for MBIWD regardless of whether the individual is receiving SSI or SSDI;
   (d) Be at least sixteen years of age but younger than sixty-five years of age;
   (e) Meet the financial eligibility requirements described in paragraph (D) of this rule;
   (f) Pay the premium, as calculated in paragraph (E) of this rule; and
   (g) Be working.

(2) To be eligible for the MBIWD medically improved covered group an individual must:
   (a) Have participated in the MBIWD basic covered group as defined in paragraph (C)(1) of this rule the previous calendar month and continue to meet all eligibility criteria described in paragraph (C) of this rule except that the individual no longer meets the disability criterion defined in paragraph (C)(1)(c) of this rule; and
   (b) Work at least forty hours per month earning at least state or federal minimum wage, whichever is lower.

(3) An individual participating in MBIWD with a medically improved disability, whose medical condition is determined, at the time of a regularly scheduled continuing disability review, to have regressed may be reevaluated for the MBIWD basic covered group in accordance with paragraph (C)(1) of this rule.

(4) If the individual is eligible for MBIWD under the basic or medically improved group and ceases to work, the individual may continue to participate in MBIWD for up to six months beginning the first day of the month after the month the individual is no longer working when:
   (a) The individual intends to return to work or look for a new job; and
   (b) The individual continues to pay MBIWD premiums, if applicable; and
   (c) The individual continues to meet all other eligibility requirements for MBIWD.

(D) Financial eligibility.

(1) For the purpose of determining whether an individual is income eligible for MBIWD, the administrative agency must compare the individual's countable income to the two hundred fifty per cent federal poverty level (FPL) for one person. Only the individual's income is considered when determining eligibility for MBIWD.
(a) From the individual's income, apply exclusions in accordance with rule 5160:1-3-03.11 of the Administrative Code, but earned income exclusions must be applied in the following order:

(i) Earned income tax credits and child tax credits;
(ii) Infrequent or irregular income;
(iii) Earned income of student children;
(iv) Any portion of the twenty dollar monthly general income exclusion which has not been excluded from unearned income;
(v) Sixty-five dollars of earned income;
(vi) Impairment-related work expenses;
(vii) One-half of remaining earned income;
(viii) Blind work expenses; and then
(ix) Any earned income used to fulfill an approved plan to achieve self-support (PASS).

(b) If the amount determined in paragraph (D)(1)(a) of this rule is no more than two hundred fifty per cent of the FPL, the individual meets the income eligibility requirement for MBIWD.

(c) If the amount determined in paragraph (D)(1)(a) of this rule exceeds two hundred fifty per cent of the FPL:

(i) An additional annual amount up to twenty thousand dollars of earned income shall be excluded.

(ii) The twenty thousand dollar earned income exclusion may be applied wholly or in part in any month to reduce the individual's countable income below two hundred fifty per cent of the FPL. This exclusion begins the first month the individual would otherwise be eligible for MBIWD and continues within the year until the twenty thousand dollars is exhausted.

(2) For the purpose of determining whether an individual meets the resource eligibility requirement for MBIWD, an individual's countable resources must not exceed the resource eligibility limit for MBIWD as defined in paragraph (B) of this rule.

(a) Only the individual's resources are considered when determining resource eligibility for MBIWD. In the case of resources which are jointly owned, the administrative agency must consider the total amount of the resource available to the individual in accordance with rule 5160:1-3-05.1 of the Administrative Code.

(b) For the purposes of determining resource eligibility for MBIWD, resources in accordance with rule 5160:1-3-05.14 of the Administrative Code are excluded.

(c) Retirement and income supplementing accounts (RISAs) are evaluated in accordance with rule 5160:1-3-03.10 of the Administrative Code.

(E) Premium calculation. An individual eligible for MBIWD whose individual income exceeds one hundred fifty per cent of the FPL for one person must pay a premium determined as follows (rounded down to the nearest dollar at each step):

(1) From the gross annual family income at the time of application and subsequent redeterminations for MBIWD, the administrative agency shall subtract one hundred fifty per cent of the FPL for the family size:

(2) From the amount determined in paragraph (E)(1) of this rule, the administrative agency shall subtract the individual's IRWE, BWE, and/or MRE:
Multiply the amount determined in paragraph (E)(2) of this rule by ten per cent. If the family’s income is less than four hundred fifty per cent of the FPL (applicable to the family size), the premium cannot exceed seven and one half per cent of the individual's income;

From the amount determined in paragraph (E)(3) of this rule, the administrative agency must subtract the amount of medical insurance premiums, including medicare premiums, paid by the family; and

Divide the amount determined in paragraph (E)(4) of this rule by twelve and round down to the nearest whole dollar. This is the individual's monthly premium.

The individual's monthly premium obligation begins the month following the month MBIWD coverage is authorized, and is due and payable in full no later than the due date established by the administrative agency.

Partial payments do not satisfy the eligibility criterion in paragraph (C)(1)(f) of this rule.

Partial payments and payments in full received after the due date established by the administrative agency are applied to the most delinquent premium.

An individual who fails to pay a premium in full for two consecutive months will be subject to eligibility termination for MBIWD in accordance with Chapter 5160:1-1 of the Administrative Code.

An individual who loses eligibility for MBIWD due to non-payment of premiums and reapply for MBIWD must:

(a) Meet all criteria in paragraph (C)(1) of this rule; and
(b) Pay all delinquent premiums for those months prior to MBIWD termination.

Individuals who are eligible for retroactive coverage in accordance with rule 5160:1-1-51 of the Administrative Code are not required to pay a monthly premium for the months of retroactive coverage.

Receipt of long-term care services in a long-term care facility, under a home and community-based services (HCBS) waiver program, or under the program of all-inclusive care for the elderly (PACE) is not a cause for termination or denial of an individual's eligibility for MBIWD.

Individuals eligible for MBIWD are not subject to a spenddown as described in rule 5160:1-3-04.1 of the Administrative Code.

Individuals eligible for MBIWD are not subject to a patient liability as described in rule 5160:1-3-04.3 or 5160:1-3-04.4 of the Administrative Code.

When an individual eligible for MBIWD, or the individual's spouse, becomes institutionalized, the resource assessment and transfer of asset provisions of rules 5160:1-3-06.3 and 5160:1-3-07.2 of the Administrative Code apply.

Individuals eligible for MBIWD are not subject to a spenddown as described in rule 5160:1-3-04.1 of the Administrative Code.

Provide the information necessary to establish eligibility, cooperate in the verification process, and report changes in accordance with rule 5160:1-1-55 of the Administrative Code.

Pay premiums determined by the administrative agency in accordance with this rule.

Process the application for MBIWD in accordance with Chapter 5160:1-1 of the Administrative Code.

Determine eligibility for MBIWD as described in this rule.
(3) Determine the premium for MBIWD as identified in paragraph (E) of this rule, and redetermine this premium during the individual’s annual redetermination or whenever the individual reports a decrease in income.

(4) Verify disability in accordance with paragraph (C)(1)(c) of this rule.

(5) Explore eligibility for qualified medicare beneficiary (QMB) and specified low income medicare beneficiary (SLMB) programs in accordance with Chapter 5160:1-3 of the Administrative Code. MBIWD individuals are not eligible for qualified individual (QI-1) or qualified working disabled individual (QWDI) medicare premium assistance programs.

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Five Year Review (FYR) Dates: 03/23/2020
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Date: 03/13/2015
Promulgated Under: 111.15
Statutory Authority: 5160.02, 5163.02
Rule Amplifies: 5160.02, 5163.02, 5163.091, 5163.092, 5163.093, 5163.094, 5163.095, 5163.096, 5163.097, 5163.098 Prior Effective Dates: 4/1/08
MEMTL 101

Effective Date: March 23, 2015

(A) This rule describes a time-limited medical assistance program, funded through the office of refugee resettlement (ORR), that provides a medical screening through contracted refugee health screening providers, and other medical services. There is no resource limit for individuals described in this rule.

(B) Definitions.

(1) "Household income" is defined in rule 5160:1-1-61 of the Administrative Code.

(2) "Derivative T visa" means either a T-2, T-3, T-4, or T-5 visa issued to certain family members of victims of a severe form of trafficking who may be eligible for RMA benefits if the visa holder meets refugee program eligibility requirements.

(3) "Individual", for the purpose of this rule, means an applicant for or a recipient of RMA or refugee cash assistance (RCA) who is not a U.S. citizen and who meets one of the following definitions of immigration status under the Immigration and Nationality Act (INA) (as in effect on September 1, 2014), as verified by documentation issued by the U.S. department of state, U.S. department of homeland security, or U.S. department of justice:

(a) Paroled as a refugee or asylee under section 212(d)(5) of the INA (as in effect on September 1, 2014).

(b) Admitted to the U.S. as a refugee under section 207 of the INA (as in effect on September 1, 2014).

(c) Granted asylum under section 208 of the INA (as in effect on September 1, 2014).

(d) Cuban and Haitian entrants in accordance with requirements in 45 C.F.R. part 401 (as in effect on September 1, 2014).

(e) Certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as contained in section 101(e) of Public Law 100-202) (as in effect on September 1, 2014), and amended by the 9th proviso under migration and refugee assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended) (as in effect on September 1, 2014).

(f) Victims of a severe form of trafficking as identified in 22 U.S.C. 7105(b)(1) (as in effect on September 1, 2014) and certain family members, as identified in the Trafficking Victims Protection Reauthorization Act of 2003 (TVPRA) (Pub. L. No. 108-193) (as in effect September 1, 2014). Victims of a severe form of trafficking are awarded a certification letter from ORR and are potentially eligible for RMA as described in 28 C.F.R. 1100.33 (as in effect on September 1, 2014). Certain family members are awarded "Derivative T" visas and are potentially eligible for RMA.

(g) Admitted as an Afghan or Iraqi special immigrant under section 101(a)(27) of the INA (as in effect on September 1, 2014).

(C) Eligibility criteria.

(1) The individual shall be neither:

(a) Eligible for medicaid; nor
(b) A full-time student in an institution of higher education, except where such enrollment is approved by the state, or its designee, as part of an individual employability plan as described in rules to 5101:1-2-40.5 of the Administrative Code.

(2) The individual meets the income requirements for RMA when:
   (a) The individual's household income is no more than the RMA need standard, or
   (b) The individual whose household income is more than the RMA need standard spends down household income to the RMA need standard, in accordance with the methods set forth in rule 5160:1-3-04.1 of the Administrative Code.

(3) Initial and ongoing eligibility for RMA is based on the applicant's income on the date of application.

(D) Eligibility period. An individual who meets the eligibility requirements of this rule may receive RMA for a time-limited period not to exceed eight months from the individual's date of entry or from the date status is granted, as listed on the individual's U.S. citizenship and immigration services' (USCIS) documentation.

(E) Individual responsibilities. The individual shall:
   (1) Provide:
       (a) USCIS documentation of alien status;
       (b) The name of the resettlement agency, if any, that resettled the individual; and
       (c) The information necessary to establish eligibility, cooperate in the verification process, and report changes in accordance with rule 5160:1-1-58.2 of the Administrative Code.
   (2) Spend down to the RMA need standard if the household income exceeds the RMA need standard; and
   (3) Cooperate in providing verification of any third-party liability or coverage of medical expenses as defined in Chapter 5160:1-1-58 of the Administrative Code.

(F) Administrative agency responsibilities. The administrative agency shall:
   (1) Accept an application, or electronic equivalent, for medical assistance as an application for RMA;
   (2) Not require an individual to apply for or receive RCA;
   (3) Not require a face-to-face interview;
   (4) Use actual countable family income for the month of application. Do not average income prospectively in determining income eligibility for RMA;
   (5) Determine medicaid eligibility, as described in Chapters 5160:1-1 to 5160:1-5 of the Administrative Code, prior to determining eligibility for RMA;
   (6) Call the trafficking verification line to confirm the validity of the certification letter or letter for children and to notify ORR of the benefits for which the individual has applied;
   (7) Make eligible an individual who receives RCA and who meets the eligibility requirements of this rule;
   (8) Obtain third-party liability information from an individual who has other health insurance; and
   (9) Explore retroactive eligibility for RMA, as defined in Chapter 5160:1-1-51 of the Administrative Code. Retroactive eligibility cannot begin prior to the individual's date of entry or from the date status is granted.

Replaces: 5160:1-6-90
Effective: 03/23/2015
Five Year Review (FYR) Dates: 03/23/2020
MEMTL 79

Effective Date: January 8, 2012

(A) This rule describes the state option medicaid covered group eligibility criteria for an individual seeking family planning services as described in section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (as in effect March 23, 2010). There is no resource limit for individuals described in this rule.

(B) Definitions.

(1) "Family planning related services" has the same meaning as in Chapter 5101:3-21 of the Administrative Code.

(2) "Family planning services" has the same meaning as in Chapter 5101:3-21 of the Administrative Code.

(C) Eligibility criteria. To be eligible for family planning services or family planning related services under this rule, the individual shall:

(1) Be a male or female.

(2) Meet the conditions of eligibility outlined in rule 5101:1-38-01.8 of the Administrative Code.

(3) Meet the financial eligibility requirements described in paragraph (D) of this rule.

(4) Not be otherwise eligible for medicaid.

(5) Not have creditable coverage as defined in rule 5101:1-37-01 of the Administrative Code.

(D) Financial eligibility.

(1) The net countable family income is no more than two hundred per cent of the federal poverty level (FPL) for the appropriate family size plus one.

(a) If the individual is married and living with the individual's spouse, the spouse's income shall be counted.

(b) If the individual is younger than eighteen, unmarried, and living with the individual's parent(s), the income of the parent(s) shall be counted.

(2) To determine net countable family income:

(a) Total the individual's gross, non-exempt income.

(b) Allocate income of a step-parent, parent of a minor parent, spouse of a specified relative, or non-qualified alien parent as described in rule 5101:1-38-02.3 of the Administrative Code, who is living with the individual, but is not a member of the covered group.

(i) From the step-parent, parent of a minor parent, spouse of a specified relative, or non-qualified alien parent's income, deduct the following:

(a) The first ninety dollars of the gross earned income.

(b) An amount equal to the allocation allowance standard, in accordance with Chapter 5101:1-23 of the Administrative Code, for the step-parent, parent of a minor parent, spouse of a specified relative, or a non-qualified alien parent and any other individuals living with but not members of the covered group, who are or could be claimed by the stepparent, parent of a minor parent, spouse of a specified relative, or non-qualified alien parent as dependents.

(c) The amount of verifiable payments made to those who are or could be claimed by the step-parent, parent of a minor parent, spouse of a specified
relative, or non-qualified alien parent, as dependents for federal personal income tax liability, but are not living in the home.

(d) The amount of alimony or child support payments made for those not living in the home.

(ii) The remaining amount of earned and unearned income is allocated to the individual as unearned income.

(c) Apply the income exemptions and disregards described in rule 5101:1-38-01.9 of the Administrative Code, and

(d) Apply the following additional exemptions:

(i) The first fifty dollars of court-ordered child support received by the covered group.

(ii) Court-ordered child support and alimony payments made to individuals not living in the household.

(iii) Earned income of a child, who is a fulltime student as defined by the educational facility, for up to six months per calendar year, and

(e) Disregard from earned income of each employed covered group member:

(i) Up to ninety dollars for each employed covered group member.

(ii) Out of pocket dependent care costs, paid to an individual who is not a member of the covered group, for a dependent child or incapacitated adult, up to but not exceeding:

(a) Two hundred dollars per infant, under two years of age, in full-time care at twenty-five hours of care per week.

(b) One hundred seventy-five dollars per child over two years of age, or incapacitated adult, in full-time care at least twenty-five hours of care per week.

(c) One hundred twenty dollars per child or incapacitated adult, in part-time care less than twenty-five hours of care per week.

(f) Earned income disregard penalties. The disregards of earned income do not apply when:

(i) An individual terminated employment or reduced earned income without good cause within the preceding month.

(ii) An individual refused a bona fide offer of employment within the preceding month without good cause.

(iii) An individual failed to timely report income in accordance with rule 5101:1-38-01.2 of the Administrative Code, without good cause.

(E) Administrative agency responsibilities. The administrative agency shall:

(1) Compare the net countable family income to two hundred per cent of the federal poverty level (FPL) for the appropriate family size plus one.

(2) Redetermine eligibility for family planning services annually in accordance with rule 5101:1-38-01.2 of the Administrative Code.

(3) Complete a pre-termination review (PTR) of continuing medicaid eligibility in accordance with rule 5101:1-38-01.2 of the Administrative Code.

(4) Issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

(F) Individuals receiving services under this covered group shall receive a fee-for-service medicaid card. Individuals eligible under this rule shall receive a limited benefit package described in rules 5101:3-21-02 and 5101:3-21-02.3 of the Administrative Code and shall not be covered by a managed care plan described in Chapter 5101:3-26 of the Administrative Code.
Retroactive coverage is available for this program in accordance with rule 5101:1-38-01.2 of the Administrative Code, but coverage shall not begin prior to the effective date of this rule and shall not provide reimbursement of services rendered prior to the effective date of this rule.

Effective: 01/08/2012
R.C. 119.032 review dates: 01/01/2017
Certification: CERTIFIED ELECTRONICALLY
Date: 12/29/2011
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011
Rule Amplifies: 5111.01, 5111.011
The purpose of RSS is to provide cash assistance to Medicaid-eligible aged, blind, or disabled adults who have increased needs due to a medical condition which is not severe enough to require institutionalization. The RSS cash payment is used together with the individual's personal income to help prevent premature or unnecessary institutionalization, and to deinstitutionalize those aged, blind, or disabled adults who have been inappropriately placed in long term care facilities and who can return to the community through alternative living arrangements.

Definitions.

(1) "Individual." for the purpose of this rule, means a person who is applying for or receiving RSS benefits.

(2) "RSS administrative agency" means the Ohio department of mental health or its designee.

RSS registration and enrollment process.

(1) The RSS application process is initiated upon receipt of:

(a) A completed JFS 07120 "Residential State Supplement Referral" (rev. 3/2002) from the residential state supplement administrative agency verifying that the individual has been selected for placement in the RSS program; and

(b) A Medicaid application, if the individual is not currently in receipt of Medicaid.

(2) If the individual completes the JFS 07120 at the CDJFS, a copy of the JFS 07120 will be forwarded to the residential state supplement administrative agency to register the individual for the RSS program.

(3) If the individual submits the JFS 07120 to the CDJFS by mail, a copy of the JFS 07120 will be forwarded to the residential state supplement administrative agency to register the individual for the RSS program.

(4) The signature date on the JFS 07120 shall be the RSS application date. In some instances, Medicaid retroactive eligibility must be determined in accordance with Chapter 5101:1-38 of the Administrative Code to cover the RSS protected date.

County department of job and family services responsibilities.

(1) The determination of eligibility for RSS shall be coordinated between the CDJFS and the residential state supplement administrative agency.

(a) The CDJFS is responsible for determining eligibility for Medicaid and financial eligibility for RSS.

(b) The residential state supplement administrative agency is responsible for determining eligibility for RSS placement, appropriate level of care and the subsequent monitoring of the placement to insure that the individual's needs continue to be met.

(c) The CDJFS shall inform the residential state supplement administrative agency of the individual's eligibility for Medicaid and an RSS payment, the type of RSS living arrangement that can be supplemented, and the amount of the RSS payment that can be authorized. Since the RSS financial need standards vary according to the RSS living arrangement, an individual or couple may be eligible for an RSS payment for one type of RSS living arrangement but not another.

(d) The CDJFS shall also inform the residential state supplement administrative agency of any change in the individual's or couple's Medicaid and/or RSS financial eligibility.
Once the individual has been selected for enrollment, the CDJFS in the county in which the individual resides shall accept and process the JFS 07120 that has been submitted by the residential state supplement administrative agency in accordance with the application procedures outlined in Chapter 5101:1-38 of the Administrative Code. A copy of the JFS 07120 shall be maintained in the assistance group’s case record that is located in the CDJFS.

For an individual who is not already receiving medicaid, the CDJFS shall preview medicaid eligibility and RSS financial eligibility within five working days of receipt of the JFS 07120 and medicaid application from the residential state supplement administrative agency.

For an individual who is receiving medicaid, the CDJFS shall, within five working days of receipt of the JFS 07120, determine if the individual meets the RSS financial eligibility criteria. The CDJFS must notify the residential state supplement administrative agency of the results of the preview of RSS and medicaid eligibility.

The CDJFS shall not delay the determination of eligibility for other assistance programs when RSS eligibility is still pending.

The CDJFS shall not treat the level of care determination for RSS eligibility as evidence that the limiting physical factor requirement for medicaid eligibility as defined in rule 5101:1-39-03 of the Administrative Code has been met.

If RSS income or resource eligibility are not met, the CDJFS shall deny the RSS application. The denial notice shall be sent to the applicant and authorized representative, if any. A copy of the denial notice shall also be issued to the residential state supplement administrative agency.

The CDJFS shall document in the case record that the individual has received an appropriate level of care determination, and shall identify the RSS placement.

Individual responsibilities.

The individual shall cooperate with the CDJFS in order to determine eligibility for RSS.

The individual is responsible for reporting changes within ten days to the CDJFS.
Non-financial eligibility requirements. The individual must complete a JFS 07120 "Residential State Supplement Referral" (rev. 3/2002) and meet all of the following criteria to be enrolled into the RSS program:

1. A county department of job and family services (CDJFS) must have determined the individual to be eligible for medicaid.
2. The individual must currently reside in a skilled nursing facility or need at least a protective level of care as defined in rule 5101:3-3-08 of the Administrative Code.
3. The individual must not require more than one hundred twenty days of skilled nursing care, as defined in section 3721.01 of the Revised Code, during any twelve month period unless the individual resides in a licensed residential care facility authorized to provide skilled nursing care in accordance with section 3721.011 of the Revised Code.
4. The individual must not have a cognitive impairment which requires the presence of another person on a twenty-four hour a day basis for the purpose of supervision to prevent harm.
5. The individual must be accepted for placement or residing in an approved community living arrangement, and a residential state supplement administrative agency must have determined that the facility is appropriate for the individual's needs in accordance with section 5119.69 of the Revised Code. The appropriate living arrangements are:
   a. An "adult foster home" certified under section 5119.692 of the Revised Code;
   b. An "adult family home" as defined in section 5119.70 of the Revised Code, that is licensed as an adult care facility under section 5119.73 of the Revised Code;
   c. An "adult group home" as defined in section 5119.70 of the Revised Code, that is licensed as an adult care facility under section 5119.73 of the Revised Code;
   d. A "residential care facility" as defined in section 3721.01 of the Revised Code, that is licensed under section 3721.02 of the Revised Code;
   e. A residential facility of the type defined in section 5119.22 of the Revised Code, that is licensed by the Ohio department of mental health; or
   f. An apartment or room that is used to provide community mental health services, is certified by the Ohio department of mental health under section 5119.611 of the Revised Code, and is approved by a board of alcohol, drug addiction, and mental health services in accordance with section 340.03 of the Revised Code.
6. The individual must not be related to the owner or caregiver of the RSS living arrangement.
7. The individual must not be a participant in any federal 1915C waiver program.
8. The individual must not be a participant in ODJFS' program of all-inclusive care for the elderly (PACE).
9. The individual must not be enrolled in a medicare or medicaid-certified hospice program.
10. The residential state supplement administrative agency must have funds available to make another RSS placement.
11. The individual must agree to participate in the development of a plan of care that includes residential needs and supports, and must sign the RSS resident agreement.
The individual must execute a release of information form permitting exchange of information between the RSS provider and other care providers and key contacts as needed for continuity of care and eligibility determination.

An individual who has been selected by the residential state supplement administrative agency for an RSS enrollment eligibility determination, or the individual's authorized representative, must apply for medicaid if he or she is not currently a medicaid recipient. The application for medicaid must be filed with the CDJFS within thirty days of the day the individual is notified of the selection.

Financial eligibility requirements.

1. The definitions of earned and unearned income in Chapter 5101:1-37 of the Administrative Code are applicable to the RSS program.

2. When a husband and wife reside in the same RSS facility and both have appropriate levels of care, the CDJFS shall determine their RSS financial and resource eligibility collectively utilizing the appropriate couple need standards.

3. When a husband and wife reside in the same RSS facility and only one of them has an appropriate level of care, the CDJFS shall determine RSS financial and resource eligibility utilizing the appropriate individual need standard. The spouse who does not have the necessary level of care shall have medicaid eligibility determined in accordance with Chapter 5101:1-39 of the Administrative Code as an individual with one exception: income cannot be deemed to or from the RSS-eligible spouse.

4. The financial eligibility methodologies for medicaid and RSS are the same, with three exceptions:
   a. SSI income is countable income in the RSS program, except that all SSI cost-of-living adjustments after October 1, 1982, are disregarded for all RSS assistance groups with SSI income.
   b. The medicaid spenddown provision does not apply in the RSS program. If an individual has countable income equal to or in excess of the financial need standard for the appropriate RSS living arrangement, the individual is ineligible for RSS.
   c. The RSS program has no deeming provision. For an RSS spouse and a non-RSS spouse residing in the same living arrangement, there is no deeming to or from the RSS spouse. They are both treated as individuals for purposes of determining RSS eligibility. If applicable, the non-RSS spouse shall have medicaid eligibility determined as an individual in accordance with Chapter 5101:1-39 of the Administrative Code with no deemed income allocation from the RSS spouse.

5. Twenty dollars of any income, earned or unearned other than income from SSI, is disregarded. Only one twenty dollar disregard is applied per couple if both husband and wife are eligible for RSS.

6. The disregard allowed from an eligible individual's earned income is sixty-five dollars plus one-half of the remaining income.

7. Earnings which are used to pay for blind work expenses and/or impairment-related work expenses may be deducted from the earned income in accordance with Chapter 5101:1-39 of the Administrative Code.

8. If the RSS individual's countable income is less than the financial need standard for the appropriate RSS living arrangement, but the individual's RSS enrollment is not yet completed, the CDJFS shall pend the RSS application until the RSS enrollment determination is completed.

9. If the RSS individual's countable income is less than the financial need standard for the appropriate RSS living arrangement, the individual is eligible for an RSS payment.
(10) The CDJFS shall determine retroactive medicaid eligibility in accordance with Chapter 5101:1-38 of the Administrative Code for coverage of non-RSS medicaid services.

(11) Qualified medicare beneficiary (QMB) and specified low-income medicare beneficiary (SLMB) eligibility determinations.

(a) QMB and SLMB eligibility determinations shall be made upon application for all programs, including RSS. If eligible, the CDJFS shall approve QMB or SLMB unless the individual, after having been fully informed of the benefits of each covered group, chooses not to have QMB or SLMB approved.

(b) If QMB or SLMB eligibility does not exist, the CDJFS shall deny QMB or SLMB. If RSS eligibility is subsequently approved, the CDJFS shall enroll the individual in the state buy-in only.

(c) QMB and SLMB financial eligibility is determined for the husband and wife as a couple even if only one has an appropriate level of care.

Replaces: 5101:1-17-02, 5101:1-17-04
Effective: 09/29/2011
R.C. 119.032 review dates: 09/01/2016
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Date: 09/19/2011
Promulgated Under: 111.15
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Rule Amplifies: 5111.01, 5111.011, 5119.69
Prior Effective Dates: 12/1/82, 7/1/83 (temp.), 9/24/83, 9/1/84, 1/1/89 (Emer.), 3/6/89, 9/12/91 (Emer.), 12/2/91, 11/1/93 (Emer.), 1/30/94, 5/1/94 (Emer.), 7/24/94, 7/1/95 (Emer.), 9/24/95, 4/1/96, 10/1/02, 7/1/11 (Emer.)
MEMTL 76

Effective Date: September 29, 2011

Most Current Prior Effective Date: July 1, 2011 (Emergency)

(A) The residential state supplement (RSS) payment to the assistance group shall be equal to the difference between the countable income and the financial need standard for the appropriate RSS living arrangement.

(B) The approval date for the RSS payment cannot precede the signature date on the JFS 07120 "Residential State Supplement Referral" (rev. 3/2002), the date of placement in an appropriate RSS living arrangement, or the date when all financial and resource eligibility requirements are met, whichever occurs last.

(C) When an individual leaves an RSS placement after the monthly RSS payment has been made, a refund of the payment will not be made to the individual. If an individual leaves an RSS placement and moves to another RSS living arrangement and the monthly RSS payment has been made to the previous residence, a second monthly RSS payment will not be made for the new residence.

(D) When an individual leaves an RSS placement the CDJFS must determine the individual's continued medicaid eligibility. If an adverse action is required (e.g., a change to delayed spenddown medicaid) the individual must be afforded hearing rights in accordance with Chapter 5101:6-2 of the Administrative Code.

(E) When an individual moves from a nursing facility or a personal residence into an RSS living arrangement the first day of the month and is otherwise eligible for RSS, the individual is eligible for a full month's RSS payment.

(F) When an individual moves into an RSS living arrangement on a date other than the first of the month and is otherwise eligible for RSS, the first month's payment is calculated according to the following formula:

1. Determine the regular monthly RSS payment in accordance with paragraph (A) of this rule.
2. Divide the monthly RSS payment amount by the number of days in the month to arrive at the daily supplement amount. Round amounts up to the nearest dollar.
3. Multiply the daily supplement amount by the actual number of days of RSS placement in the month. The actual number of days of RSS placement in the month includes the day that the individual moves into the RSS living arrangement through the last day of the month.
4. The resulting product is the prorated RSS payment.

(G) Impact of temporary institutional placement.

1. Individuals who temporarily enter a public or medicaid certified facility are potentially eligible to receive full uninterrupted RSS benefits during the first three full months of institutional placement. These RSS benefits are intended to allow the individual to maintain and pay for the expense of the RSS living arrangement in which the individual intends to live when discharged.

2. Individuals are eligible for continued RSS benefits provided the following criteria are met:
   a. Institutional placement. The individual must continuously reside in one or more of the following: a public medical institution, a public psychiatric institution, a medicaid approved hospital, or a Title XIX certified long term care facility (LTCF).
   b. Recipient status. The individual must be eligible for an RSS payment both the month prior to and the month of institutional placement.
   c. Physician's certification. The individual's physician must provide a statement that the individual's period of institutional placement is not likely to exceed ninety consecutive days, beginning the day after the day of admission.
Need to maintain the RSS facility placement. The individual must demonstrate the need to continue to maintain the placement in the RSS facility during the institutional placement, and that the RSS facility will reserve the individual's space. A written statement from the RSS facility to this effect is necessary.

Evidence documenting that the criteria listed in paragraphs (G)(2)(a) to (G)(2)(d) of this rule have been met must be provided by the earlier of:

(i) Ninety days after the date of admission to the institution; or
(ii) The day of release from the institution.

Evidence documenting that the criteria listed in paragraphs (G)(2)(a) to (G)(2)(d) of this rule have been met must be provided by the earlier of:

(i) Ninety days after the date of admission to the institution; or
(ii) The day of release from the institution.

Evidence documenting that the criteria listed in paragraphs (G)(2)(a) to (G)(2)(d) of this rule have been met must be provided by the earlier of:

(i) Ninety days after the date of admission to the institution; or
(ii) The day of release from the institution.

Evidence documenting that the criteria listed in paragraphs (G)(2)(a) to (G)(2)(d) of this rule have been met must be provided by the earlier of:

(i) Ninety days after the date of admission to the institution; or
(ii) The day of release from the institution.

Evidence documenting that the criteria listed in paragraphs (G)(2)(a) to (G)(2)(d) of this rule have been met must be provided by the earlier of:

(i) Ninety days after the date of admission to the institution; or
(ii) The day of release from the institution.
MEMMTL 2

Effective Date: October 1, 2013

(A) This rule describes the migration of Administrative Code rules regarding eligibility categories and eligibility determination processes as the department of medicaid (ODM) moves to a new Administrative Code title and implements new federal requirements.

(B) Effective dates.

(1) For the determination or redetermination of eligibility for medical assistance, rules 5101:1-37-50 to 5101:1-37-58.3 of the Administrative Code are effective upon publication.

(2) For the determination of eligibility under modified adjusted gross income (MAGI) based or presumptive eligibility categories with coverage beginning on or after January 1, 2014, rules 5101:1-37-61 to 5101:1-37-65 of the Administrative Code are effective October 1, 2013 or the date of publication of the rule, whichever is later.

(3) For the determination or redetermination of eligibility under non-MAGI eligibility categories for the aged, blind, or disabled; alien status; or another non-MAGI eligibility category, with coverage beginning on January 1, 2014, Chapters 5101:1-38, 5101:1-39, 5101:1-41, and 5101:1-42 of the Administrative Code remain in effect.

(C) Conflicts between rules.

(1) Beginning October 1, 2013, or, if later, the effective date of this rule, the administrative agency must comply with Administrative Code rules 5101:1-37-50 to 5101:1-37-58.3 regarding administrative processes and the determination and redetermination of eligibility.

(2) For any benefit month prior to January, 2014, an individual may be found eligible for medical assistance under an eligibility category described in Chapter 5101:1-40 of the Administrative Code.

(3) For January, 2014 or any later benefit month, eligibility for a given category must be determined under the rules appropriate for that category:

(a) For a MAGI-based eligibility group, eligibility must be determined under rules 5101:1-37-61 to 5101:1-37-65 of the Administrative Code; or

(b) For an eligibility category based upon age, blindness, disability, alien status, or other non-MAGI basis, eligibility must be determined under Chapters 5101:1-38, 5101:1-39, 5101:1-41, and 5101:1-42 of the Administrative Code.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 111.15

Statutory Authority: 5111.01

Rule Amplifies: 5111.01
This rule contains definitions generally used in determining medicaid eligibility.

Definitions.

1. "Abuse" means individual practices resulting in unnecessary cost to the medical assistance program.

2. "Administrative agency" means the Ohio department of medicaid (ODM) and/or an agent of ODM authorized to determine eligibility for a medical assistance program.


4. "Assignment" means a medicaid-eligible individual has transferred the right to collect and retain third-party and medical support payments only to the extent of medical services which are paid under the medicaid program.

5. "Authorized representative" means an individual, at least eighteen years old, or a legal entity who stands in place of the individual and shares the individual's responsibilities. Actions or failures of an authorized representative have the same effect as if the individual did them. If an individual has designated an authorized representative, all references to "individual" in regard to an individual's responsibilities include the individual's authorized representative.

6. "Caretaker relative" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes), and who is one of the following:
   a. The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, or stepsister.
   b. The child's aunt, uncle, nephew, or niece, including such relatives with the prefix great, great-great, grand, or great-grand.
   c. The child's first cousin or first cousin once removed.
   d. The spouse of such parent or relative, even after the marriage is terminated by death or divorce.

7. "Case record" means electronic or paper documents and information used to determine or redetermine an individual's eligibility for medical assistance.

8. "CDJFS" means a county department of job and family services.

9. "Certificate of creditable coverage" means a written certificate, issued by a health plan or health insurance issuer, that states the period of time an individual was or has been covered by the health plan. A certificate of creditable coverage must contain information about the duration of coverage and an educational statement that describes the individual's health insurance portability rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

10. "Confined" means serving time for a criminal offense or involuntary placement in a prison, jail, detention facility, or other penal facility. The term "confined":
   a. Includes placement while awaiting trial, sentencing, or other involuntary detainment determination.
Does not include placement in a public institution pending arrangements appropriate to an individual's needs.

"Conviction" or "convicted" means a judgment of conviction has been decided by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

"Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (as in effect on September 1, 2013).

(a) This includes:

(i) A group health plan.

(ii) Health insurance coverage.

(iii) Medicare part A, as set forth in 42 U.S.C. 1395c to 1395i-5. (as in effect on April 1, 2013) or part B, as set forth in 42 U.S.C. 1395j to 1395w-4 (as in effect on April 1, 2013).

(iv) Coverage under medicaid, as set forth in Title XIX of the Social Security Act, other than coverage consisting solely of benefits under the pediatric vaccine program set forth in 42 U.S.C. 1396s (as in effect on April 1, 2013).

(v) Armed forces health insurance as set forth in 10 U.S.C. 1071 to 1110a (as in effect on April 1, 2013).

(vi) A medical care program of the Indian health service or of a tribal organization.

(vii) A state health benefits risk pool.

(viii) A federal employee health plan offered under 5 U.S.C. 8901 to 8992 (as in effect on April 1, 2013).

(ix) A public health plan.

(x) A peace corps volunteer health benefit plan under section 22 U.S.C. 2504 (as in effect on April 1, 2013).

(b) Creditable insurance does not include:

(i) Coverage only for accident, or disability income insurance.

(ii) Liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance.

(iii) Workers' compensation or similar insurance.

(iv) Automobile medical payment insurance.

(v) Credit-only insurance.

(vi) Coverage for on-site medical clinics.

(vii) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

(viii) Limited-scope dental or vision benefits.

(ix) Benefits for long-term care, nursing home care, home health care, or community-based care.

(x) Coverage only for a specified disease or illness.

(xi) Hospital indemnity or other fixed indemnity insurance, if purchased separately.

(xii) Medicare supplemental health insurance as defined under 42 U.S.C. 1395ss (as in effect on April 1, 2013), coverage supplemental to the coverage provided to military or former military personnel under 10 U.S.C. Chapter 55 (as in effect on April 1, 2013), and similar supplemental coverage provided to coverage under a group health plan.
"Dependent child" means a person younger than age eighteen living with a parent or caretaker relative.

"Electronic equivalent" means an electronic version of an ODJFS or ODM form or application which has not been modified in any way other than format prior to completion and submission of that form to the administrative agency. The administrative agency is not required to accept forms that are materially altered.

"Electronic protected health information" (ePHI) means any protected health information (PHI) that is in electronic form, maintained or transmitted, regardless of the format.

"Electronic signature" has the same meaning as in section 1306.01 of the Revised Code.

"EPSDT" means early and periodic screening, diagnosis and treatment as described in rule 5101:1-38-05 of the Administrative Code, also referred to as healthchek.

"Erroneous payment" means a medicaid reimbursement made for an individual who was ineligible at the time services were received. An erroneous payment may occur as a result of fraud or non-fraud.

"Family size" means the number of persons counted as members of an individual's medicaid household.

"Federal adoption assistance" (AA) means the Title IV-E subsidy program as defined by the Adoption Assistance and Child Welfare Act of 1980.

"Federal means-tested public benefit" means a benefit in which eligibility for the benefit or the amount of the benefit, or both, is determined on the basis of income or resources of the individual seeking the benefit. Medicaid, cash assistance, and food assistance are federal means-tested public benefits, but certain other benefits listed in 8 U.S.C. 1613(c) (as in effect on September 1, 2009) are not considered means-tested.

"FPL" means the federal poverty level determined annually by the office of management and budget as required by 42 U.S.C. 9902(2) (as in effect on April 1, 2013).

"Foster care maintenance" (FCM) means Ohio's Title IV-E foster care maintenance program, as described in rule 5101:2-47-01 of the Administrative Code.

"Good cause" means circumstances that reasonably prevent an individual from cooperating with the administrative agency in the eligibility determination process. Factors relevant to good cause include, but are not limited to: natural disasters; riots or civil unrest; death or serious illness of the individual or a member of his/her immediate family; or the physical, mental, educational, or linguistic limitations of the individual.

"HCB services" or "HCBS" means specific home and community-based services furnished under the provision of 42 C.F.R. 441, subpart G (as in effect on April 1, 2013), that provide specific individuals an alternative to placement in a hospital, a nursing facility (NF), or an intermediate care facility for persons with mental retardation (ICF/MR) as set forth in rule 5101:3-1-06 of the Administrative Code.

(a) HCB services are approved by the federal centers for medicare and medicaid services (CMS) for certain individuals and are not otherwise covered by medicaid. These services may be provided:

(i) Only in certain areas of the state, and
(ii) Only to certain individuals.

(b) To receive HCB services, an individual must:

(i) Be eligible for medicaid;
(ii) Apply separately for HCB services; and
(iii) Be found eligible to receive HCB services.
"Home and community-based (HCB) services waiver operational agency" means ODM or its designee that performs administrative functions related to an HCB services waiver program in accordance with division 5101:3-Chapter 5160-1 of the Administrative Code.

"Household income" is the sum of the MAGI-based income of every person included in an individual's medicaid household.

"Immigrant" means a person who comes to the United States with plans to live here permanently. This term includes refugees, asylees, parolees, and other entrants, both legal and illegal.

"Income" means any benefit in cash or in-kind, received by an individual during a calendar month.

"Income and eligibility verification system" (IEVS) means the electronic system that shares income and asset information among the social security administration (SSA), internal revenue service (IRS), and the administrative agency.

"Independent living services" has the same meaning as in rule 5101:2-42-19 of the Administrative Code.

"Individual" means a person applying for or receiving medical assistance.

"Individually identifiable health information" means information that is a subset of health information including demographic information collected from an individual and:

(a) Is created or received by a health care provider, health plan, employer or health care clearinghouse; and

(b) Relates to the past, present, or future physical condition or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual and either:

(i) Identifies the individual; or

(ii) There is a reasonable basis to believe the information can be used to identify the individual.

"Initial processing" means taking applications for medical assistance, assisting applicants in completing the application, providing information and referrals, obtaining required documentation needed to complete processing of the application, and assuring completeness of the information contained on the application. Initial processing does not include evaluating the information on the application and supporting documentation, or making a determination of eligibility.

"Institution for mental diseases" (IMD) means a hospital, nursing facility, or other institution of more than sixteen beds which primarily provides diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

(a) A facility is an IMD, whether or not it is licensed as such, if it is operated primarily for the care and treatment of individuals with mental diseases.

(b) An institution for persons with cognitive impairments or other developmental disabilities is not an IMD.

"Limited English proficiency" (LEP) means the inability of any person or group of persons to speak, read, write or understand the English language at a level that allows them to meaningfully communicate with the administrative agency.

"MAGI-based income" has the same meaning as in 42 C.F.R. 435.603 (as in effect on September 1, 2013).


"Medicaid eligibility fraud" means that an individual knowingly:
(a) Made or caused to be made a false or misleading statement; or
(b) Concealed an interest in property or failed to disclose certain transfers of property.

(36)(40) "Medicaid household" means the a group of individuals, defined in relationship to one specific medical assistance applicant or recipient, who impact the applicant or recipient’s family size or household income.

(37)(41) "Medical support" has the same meaning as in section 5101.571-5160.35 of the Revised Code.

(38)(42) "Medical verification of pregnancy" means a written statement signed by a doctor or nurse verifying pregnancy and includes the expected date of confinement and, if more than one, the expected number of fetuses.

(39)(43) "Non-applicant" means an individual who is not seeking an eligibility determination for himself or herself but is included in an applicant’s or beneficiary’s medicaid household to determine eligibility for such applicant or beneficiary

(40)(44) "Non-cooperation" or "failure to cooperate" means failure by an individual to present required verifications, or to explain why it is not possible to present the verifications, after being notified the verification was required for eligibility determination.

(41)(45) "ODJFS" means the Ohio department of job and family services.

(42)(46) "ODM" means the Ohio department of medicaid.

(47) "Outstationing" means the federal requirement that administrative agencies provide opportunities for low-income pregnant women and children to apply for medicaid at locations other than the local county department of job and family services.

(48) "OWF sanction" means that an adult member of an Ohio works first (OWF) assistance group, as a result of his or her own failure, has become ineligible for OWF payments for at least six months due to a third or subsequent failure or refusal, without good cause, to comply in full with a provision of a self-sufficiency contract related to a work activity.

(49)(49) "Parent" means a natural or adoptive parent, or step-parent, or legal guardian.

(50)(50) "PCPA" means a private child placing agency as defined in rule 5101:2-1-01 of the Administrative Code.

(51) "PCS A" means a public children services agency as required by section 5153.02 of the Revised Code.

(52) "Personal knowledge" means first-hand knowledge of circumstances of an event. A person verifying an event, based on personal knowledge, should be able to share such details as when and where the event occurred, who was involved and whether there were any special circumstances surrounding the event.

(53) "Postpartum period" means a span of at least sixty days, beginning on the date a woman’s pregnancy ends and ending on the last day of the month in which the sixtieth day falls.

(54) "Protected health information" (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium.

(55) "PTR" means pre-termination review as set forth in rule 5101:1-37-51-5160:1-1-51 of the Administrative Code. This is done prior to any termination of assistance to determine whether an individual is eligible for any other category of assistance.

(56) "Public institution" means an institution which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(57) "Qualified entity" means:

(a) A county department of job and family services (CDJFS); or
A hospital, federally qualified health center (FQHC) or FQHC look-alike, as described in Chapter 5101:3-28-5160-28 of the Administrative Code, that:

(i) Has requested to serve as a qualified entity, and

(ii) Has been determined by ODM to be capable of making presumptive eligibility determinations, and

(iii) Is currently in compliance, as determined by ODM, with the presumptive eligibility operating addendum to its provider agreement.

"Redetermination" means a review to determine whether the individual continues to meet all of the eligibility requirements of the medical assistance category. A redetermination is performed periodically or when information about possible changes to an individual's eligibility is received by the administrative agency.

"Refugee" means a person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.

"Reporting" means notifying the administrative agency of any changes that may affect an individual's eligibility for medical assistance. Reporting changes and providing verifications is the responsibility of any individual, person, or entity who has a legal or financial responsibility for or who stands in the place of an individual, including:

(a) The individual;
(b) The individual's spouse, including a community spouse;
(c) The individual's parent, guardian, or specified relative; and
(d) The individual's authorized representative.

"Residence" means the place the individual considers his or her established or principal home and to which, if absent, he or she intends to return.

"Residential care facility" (RCF) means a home that provides either of the following:

(a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment; or
(b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals, any of the skilled nursing care authorized by section 3721.011 of the Revised Code.

"Safeguarding" means security measures taken to ensure that the information of individuals applying for or receiving medical assistance is protected against unauthorized inspection, disclosure, or use. Safeguarding also refers to the restriction on the use of, or disclosure of, individual information including federal tax information and returns (FTI), any protected health information (PHI), or other confidential information used in the administration of the medicaid program.

"Self-declaration" means a statement or statements made by an individual.

"SSA" means the social security administration.

"SSN" means social security number.

"State adoption assistance" means the state-only adoption subsidy program as described in rule 5101:2-44-03 of the Administrative Code.

"Suspend" or "suspended" means the temporary closing or terminating of eligibility.
"Temporary absence" means that an individual (parent or child) who is otherwise considered part of the family is considered not to have changed residence.

(a) An individual is considered to be temporarily absent when all of the following conditions are met:

(i) The location of the absent individual is known;

(ii) There is a definite plan for the return of the absent individual to the family's place of residence; and

(iii) The absent individual shared the place of residence with the family immediately prior to the absence, except for individuals described in paragraph (B)(6) of rule 5101:1-40-02.2-5160:1-4-02.2 of the Administrative Code.

(b) Child(ren) removed by the PCSA are considered temporarily absent as long as the reunification requirements specified in the reunification plan are met.

"Terminate" or "terminated" means a determination by the administrative agency that an individual is no longer eligible, or has failed to cooperate with verification of eligibility, for one or more categories of assistance currently being received by that individual, resulting in a written notice of the administrative agency’s intention to cease coverage under that category and providing notice of hearing rights as required by 42 C.F.R. 435.919 (as in effect on April 1, 2013).

"United States citizen or national" means any individual who is:

(a) A citizen or national through birth or collective naturalization as set forth in 8 U.S.C. Chapter 12, Subchapter III, Part I (as in effect on April 1, 2013); or

(b) A naturalized citizen or national as set forth in 8 U.S.C. Chapter 12, Subchapter III, Part II (as in effect on April 1, 2013).

"Verification" means a document, statement, or other confirmation of information provided by an individual or by a third party to confirm statements made by the individual about any requirement for eligibility for medical assistance. A verification document or written statement may be an original, photocopy, facsimile (fax), or electronic version of the original, unless otherwise stated.

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MEMMTL 1

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(A) This rule describes the responsibilities of the administrative agency.

(B) Calculation of time periods for eligibility determinations. All calculations of time periods used in the determination of eligibility, including scheduled redeterminations or a redetermination as a result of a reported change, or any notice sent as a result of a determination of eligibility, shall be computed as follows:

(1) When counting the number of days in a specified time period, the initial day is excluded from the computation and the last day is included.

(2) When the last day of the time period falls on a Saturday, Sunday, or legal holiday, the time period shall end on the next working day.

(C) Effective date of applications, reported information, or requests for applications or assistance. Applications, documents, or information submitted or provided to the administrative agency, or requests made to the administrative agency, are considered received by the administrative agency:

(1) That day, if received before five p.m. on a business day, or if provided to the administrative agency during the administrative agency's office hours.

(2) On the next business day, if received by the electronic eligibility system after five p.m. or on a non-business day when the administrative agency is closed.

(D) Request for application. When an individual requests an application, the administrative agency must:

(1) Not deny an individual's right to apply or discourage an individual from applying.

(2) Inform the individual of the following:

   (a) An online application portal is available to complete an application for medical assistance.

      (i) Assistance completing the online application is available through the portal.

      (ii) Use of the online application portal will likely lead to faster determination of eligibility.

   (b) The beginning date of benefits depends on the date the signed application is submitted electronically or received by the administrative agency. The signature may be original, copied, facsimile, or electronic.

   (c) The verification requirements and deadlines.

   (d) Individuals must cooperate with eligibility determinations, redeterminations, audits and quality control processes as defined in this chapter of the Administrative Code.

   (e) The meaning of and penalties for medicaid eligibility fraud as set forth in section 2913.401 of the Revised Code.

(3) Fulfill a request for an application within a business day.

   (a) Fulfillment occurs when the administrative agency sends an electronic copy of the application or a link to an electronic copy of the application to the text or email address provided by the individual; hands the application to the individual; or places the application in the U.S. mail. If the application is provided in person or via U.S. mail, the administrative agency must enclose a preaddressed, postage-paid envelope for return of the application.
The application must be accompanied by the following documents. To the extent possible, these documents must be provided in the same manner and in the same format as the application.

(i) The JFS 07501 "Program Enrollment and Benefit Information" (rev. 10/2012).
(ii) The JFS 07217 "Voter Registration Notice of Rights and Declination" (rev. 8/2009), or a notice meeting the requirements of section 3503.10 of the Revised Code, and a voter registration form as required by section 329.051 of the Revised Code.

Upon a request for assistance or receipt of an application, the administrative agency must:

(1) Provide an interpreter at no charge to an individual with limited English proficiency and, when available, provide applications and important forms or brochures in the individual's language.

(2) Distribute voter information and registration materials as required by 42 C.F.R. 431.307 (as in effect on March 1, 2013).

(3) Coordinate with the supplemental nutrition program for women, infants and children (WIC) program. Advise any potential WIC recipient of the WIC program and refer the individual to the WIC agency by forwarding a copy of the individual's medical assistance application and any supplemental application, unless the individual is already receiving WIC assistance.

(a) The following individuals are potential WIC recipients:

(i) A woman who is:

(a) Pregnant; or
(b) Within a six-month period after termination of pregnancy; or
(c) Breastfeeding her infant within the twelve months after the infant's birth; or

(ii) A child younger than five years old.

(b) For any individual in receipt of medical assistance who is a potential WIC recipient, the administrative agency must advise the individual of the WIC program at least annually.

(4) Issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

Assistance.

(1) The administrative agency must allow a person or persons of the individual's choice to accompany, assist, and represent the individual in the application or redetermination process.

(a) A person may accompany and assist an individual without being an individual's authorized representative.

(b) The administrative agency must not reveal safeguarded information, as described in rule 5101:1-37-51.1 of the Administrative Code, or send notices or correspondence to the person assisting the individual, unless the person has been designated in writing as an authorized representative.

(c) A person who is assisting an individual must provide accurate information, to the best of his or her knowledge, regardless of whether the person is an authorized representative.

(2) If an individual has designated an authorized representative, the administrative agency must:

(a) Issue all notices and correspondence to both the authorized representative and the individual.

(b) Contact the individual to clarify or verify information provided by an authorized representative if the information provided on the application seems contradictory, unclear, or unrealistic.

(c) Remove the authorized representative from any correspondence or access to safeguarded information upon receipt of notice that:
(i) The authorized representative is declining or ending representation of the individual, or
(ii) The individual has withdrawn the representative's authority.

(3) The administrative agency must help complete the application if assistance is needed, including assistance through agents of the administrative agency, such as eligibility workers.

(a) At the individual's request, an eligibility worker must assist with completing the application by asking the individual for answers needed to complete the application, then recording the individual's answers on the application form or in the electronic eligibility system. The eligibility worker must not alter any answers given by the individual.

(b) If an eligibility worker assists or helps to complete an application, the worker must sign the application form, and include the worker's title, as a person who assisted in completing the application.

(c) The normal process of inputting data into the electronic eligibility system or determining an individual's eligibility must not be construed as providing assistance.

(4) Upon request, the administrative agency must provide assistance to individuals having difficulty gathering verifications.

(5) When determining eligibility for an individual with a physical or mental impairment that substantially limits the individual's ability to access verifications, and who has not granted any person with durable power of attorney, or who does not have a court-appointed guardian or a person with other legal authority and obligation to act on behalf of the individual, the administrative agency must:

(a) Determine if another person is available to assist with obtaining verifications or accessing the individual's means of self-support.

(i) If such a person is available, request the person assist with obtaining the verifications or accessing the individual's means of self-support.

(ii) If verifications are provided, or if means of self-support are accessed by the individual or on the individual's behalf by another person, the administrative agency must consider the verified criteria or means of self-support in the eligibility determination process.

(b) If no person is available to assist the individual:

(i) Refer the individual's case to the administrative agency's legal counsel and request counsel evaluate whether the matter should be referred to the probate court, adult protective services, or another entity deemed by the administrative agency's legal counsel to be appropriate. For cases referred to counsel for such evaluation, the administrative agency must also:

(a) Note in the individual's case record that verifications or means of self-support are not available and must not be considered a disqualifying factor until a means of access to those items is obtained or established, and

(b) Inform the administrative agency's legal counsel of any eligibility approval or denial.

(ii) Determine eligibility in accordance with Chapter 5101:1-37 of the Administrative Code, but without considering eligibility factors for which verification cannot be obtained or means of self-support that cannot be accessed because of the physical or mental impairment. Use the best evidence available without delaying the determination of eligibility.

(iii) Redetermine eligibility once a means of access to verifications or means of self-support is obtained or established. If such access has not been obtained prior to a
(G) Receipt of application. Upon receipt of any signed application for medical assistance or for specific medical assistance services or programs, the administrative agency must:

(1) Give or send a receipt to the individual showing the date of application.

(2) Accept and register an application within a business day of the time the signed application is received, whether it is an original, a facsimile, a telephonic, or an electronic signature (“e-signature”). An original signature is not required.

(a) If an application is received from a local WIC clinic, child and family health services (CFHS) clinic, or bureau for children with medical handicaps (BCMH) office within five days of the signature date, the application must be registered using the signature date. If the application is not received within five days of the signature date, the application must be registered using the date it was received by the administrative agency.

(b) If an application taken by an outstationed worker assigned to a federally qualified health center (FQHC) or a disproportionate share hospital (DSH) was not directly entered into the electronic eligibility system, it must immediately be submitted to the appropriate administrative agency, which must register the application using the signature date.

(3) The administrative agency must not delay the registration or processing of an application due to the lack of a signed acknowledgement of an individual’s rights and responsibilities.

(4) If not previously provided, give or send the following documents to the applicant:

(a) Pamphlet describing the local service programs available through the administrative agency or other county agencies;

(b) A preaddressed, postage-paid envelope for return to the administrative agency;

(c) JFS 07501; and

(d) A notice meeting the requirements of section 3503.10 of the Revised Code or JFS 07217, and a voter registration form as required by section 329.051 of the Revised Code.

(H) Verifications. Where manual verifications are required under rule 5101:1-37-58 of the Administrative Code, the administrative agency must:

(1) Follow the safeguarding guidelines set forth in rule 5101:1-37-51.1 of the Administrative Code when providing or gathering information by telephone, in person, or in electronic or written form.

(2) Not require that an individual provide verification of unchanged information unless the information is incomplete, inaccurate, inconsistent, outdated, or missing from the case record due to record retention limitations.

(3) Not request that an individual provide duplicate copies of previously submitted verifications.

(4) To the extent possible, verify relevant eligibility criteria using electronic records available through the electronic eligibility system. Where electronic verification is not available, or electronic verification data conflicts with the individual’s attestation, request verifications as set out in rule 5101:1-37-58 of the Administrative Code.

(5) If the administrative agency is unable to verify an eligibility criteria through electronic sources, the administrative agency will provide a written (electronic or on paper) request for the necessary information or verification documents.

(a) The written request must:

(i) Include the date by which the information must be provided to the administrative agency;

(ii) Inform the individual that any delay in providing requested information or documents will delay the determination of an individual’s eligibility; and
(iii) Provide information on how an individual can request assistance in gathering the requested documents.

(a) The administrative agency must assist the individual in obtaining the verifications required for eligibility determination.

(b) When the normal sources of verification described in this rule have been exhausted and no documentation can be obtained, the administrative agency may accept the individual's statement if it is complete and consistent with other facts and statements. The use of such a statement must be on a case by case basis when no other approach is possible, and must be used only in rare circumstances.

(b) If the information or verification required to establish the individual's eligibility for assistance is not received by the administrative agency by the stated date, the administrative agency must contact the individual in writing no more than twenty days from the date of the application.

(i) The follow-up letter:

(a) Must be sent via postal mail or personally delivered to the individual;

(b) Must state that the required information or verification has not been received, and that if the information or verification is not received within ten days the administrative agency shall deny the application for medical assistance; and

(c) Must include a clear statement that the administrative agency will assist with obtaining the required information or verification if the request for assistance is received on or prior to the given deadline; and

(d) Does not serve as a notice of denial of application.

(ii) If the requested information or verification is not received by the stated deadline, the administrative agency shall propose a denial or termination of benefits.

(c) The administrative agency must deny the individual's application if the individual fails to provide the necessary information or verifications, or request assistance and cooperate with obtaining verifications, within the time specified in the second verification request. If this happens:

(i) An individual may reapply at any time.

(ii) An individual should not be asked to re-verify information previously verified by the administrative agency without reason to believe the information may have changed.

(6) Give or send a dated itemized receipt for any verification document received from an individual.

(7) Record receipt of all verification documents, photocopy or scan the documents, and retain copies or images of the documents in the case record.

(8) If information is verified through a telephone contact, record the following details:

(a) The name and telephone number of the person giving the information;

(b) The name of the agency or business contacted, if applicable;

(c) The date of the contact; and

(d) An accurate summary of the information provided.

(I) Determination and redetermination of eligibility. The administrative agency must:

(1) Not schedule an interview except at the request of the applicant.
Inform all individuals at the time of application and reapplication that the agency will obtain and use information available from IEVS to assist with the determination of eligibility, as required by section 1137 of the Social Security Act (as in effect on April 1, 2013).

Using the electronic eligibility system, the administrative agency must:

(a) Determine or redetermine an individual’s eligibility for medical assistance within the application processing time limits set forth in this rule.
   (i) The administrative agency must not approve medical assistance to an individual merely because of an agency error or delay in determining eligibility. All eligibility factors must be met.
   (ii) The administrative agency must not delay the approval of medical assistance due to the lack of information or verifications necessary to determine eligibility for other public assistance programs.

(b) Document and record determinations of eligibility. The administrative agency must:
   (i) Record, in physical or electronic case records, any information, action, decision, or delay in the application, eligibility determination, or termination processes, as well as the reasons for any action, decision, or delay.
   (ii) Make the case records, physical or electronic, available for compliance audits.

(c) Approve medical assistance for an individual who:
   (i) Has signed an application under penalty of perjury; and
   (ii) Has provided all necessary verifications as set forth in rule 5101:1-37-58 of the Administrative Code; and
   (iii) Meets all conditions of eligibility for an eligibility category set forth in an approved state plan amendment, Chapter 5101:1-37, 5101:1-39, 5101:1-41, or 5101:1-42 of the Administrative Code. If an individual who attests to U.S. citizenship or qualified alien status meets all conditions of eligibility for an eligibility category except for verification of the individual’s citizenship or qualified alien status, the administrative agency must approve time-limited coverage during a reasonable opportunity period (ROP) as required in rule 5101:1-37-58.2 or 5101:1-37-58.3 of the Administrative Code.

(d) Deny an application for medical assistance for an individual who:
   (i) Has not signed an application under penalty of perjury; or
   (ii) Withdraws the application; or
   (iii) Fails to cooperate in the application or determination process or fails to provide all necessary verifications set forth in rule 5101:1-37-58 of the Administrative Code; or

(e) Suspend medical assistance upon notification that an individual meets any of the criteria for ineligibility for payment of services set forth in rule 5101:1-37-58.1 of the Administrative Code.

(f) Terminate medical assistance for an individual who:
   (i) Requests that assistance be terminated; or
   (ii) Is no longer an Ohio resident, or is deceased; or
   (iii) Fails to cooperate in the redetermination or quality control processes, or fails to provide all necessary verifications; or
(iv) Fails or refuses to comply with individual responsibilities as described in this Chapter of the Administrative Code, or is subject to an OWF sanction and has not agreed to comply with the work requirements; or

(v) No longer meets the conditions of eligibility for an eligibility category as set forth in Chapter 5101:1-37 of the Administrative Code. Before terminating coverage on this basis, the administrative agency must conduct a pre-termination review (PTR) to determine that the individual is no longer eligible for coverage under any eligibility category.

(J) Timely determinations and redeterminations. The administrative agency must make a timely determination of an individual's eligibility for medical assistance under this chapter of the Administrative Code. The administrative agency must determine or redetermine eligibility, including obtaining verifications when required, within:

(1) Ten days of receiving a report of a change that could affect an individual's on-going eligibility for medical assistance; or

(2) Thirty calendar days from the date of application or scheduled redetermination, unless:
   (a) An individual who otherwise meets the conditions of eligibility described in this chapter of the Administrative Code alleges blindness or disability. The administrative agency must determine eligibility within ninety days from the date of application unless the examining physician delays or fails to take a required action; or
   (b) There is an administrative or other emergency beyond the administrative agency's control.

(3) Forty-five days of receipt of new or changed information from IEVS. The administrative agency must not terminate, deny, or suspend benefits until appropriate steps have been taken to verify the relevant information in accordance with 42 C.F.R. 435.955(a) (as in effect on April 1, 2013).

(K) Effective dates of eligibility.

(1) Medical assistance coverage begins on the first day of the calendar month in which the application which resulted in eligibility was submitted to the administrative agency, except that:
   (a) An individual's coverage cannot begin before the date on which the individual:
      (i) Became a resident of Ohio, or
      (ii) Was born.
   (b) The administrative agency must approve retroactive eligibility for medical assistance effective no later than the first day of the third month before the month of application if the individual:
      (i) Received medical services of a type covered by medicaid at any time during that period; and
      (ii) Would have been eligible for medical assistance at the time the services were provided if an application had been made at that time, regardless of whether the individual was alive when the application actually was made.
   (iii) Is eligible for a category of medical assistance other than:
      (a) Transitional medicaid as described in rule 5101:1-40-05 of the Administrative Code; or
      (b) Medicare premium assistance as described in rule 5101:1-38-03 of the Administrative Code; or
      (c) Any presumptive eligibility category described in rule 5101:1-37-62 of the Administrative Code.
Medical assistance coverage terminates on the last day of a calendar month, except that coverage terminates on the date an individual:
(a) Becomes a resident of another state;
(b) Dies; or
(c) Requests that coverage be terminated.

Duration of eligibility span. The administrative agency must:
(1) Terminate coverage under a time-limited eligibility category as described in the Administrative Code rule for the appropriate eligibility category. These time-limited eligibility categories include:
(a) Any presumptive eligibility category, described in rule 5101:1-37-62 of the Administrative Code, and
(b) Alien emergency medical assistance, as described in rule 5101:1-41-20 of the Administrative Code.

(2) Redetermine an individual's eligibility for medical assistance on the earlier of the following:
(a) One year after the most recent eligibility determination, or
(b) Upon receiving a report of a change in circumstances that could affect an individual's eligibility for medical assistance.

Third party liability (TPL). For individuals found eligible for or in receipt of medical assistance, the administrative agency must report to the Ohio department of medicaid (ODM) any available information about a third party liable for an individual's health care costs.
(1) When determining an individual's eligibility for medical assistance coverage, the agency must use the form (or an electronic equivalent) designated by the administrative agency to report:
(a) Possible health insurance coverage of an individual. A separate report must be made for each possible health insurance policy.
(b) Potential TPL due to an injury, disability or court order.

(2) At a redetermination, or upon any reported change, the administrative agency must compare the individual's current information to the information on the most recent JFS 06612 "Health Insurance Information Sheet" (rev. 5/2001) or JFS 06613 "Accident/Injury Insurance Information (rev. 6/2009). If any information has changed, the administrative agency must report the changes to ODM by submitting a new JFS 06612 or JFS 06613, or an electronic equivalent.

(3) Upon a request by ODM, the administrative agency must contact the individual to obtain information about potential TPL. If the individual fails to cooperate, the agency must propose to terminate or deny the individual's medical assistance for failure to cooperate, as set forth in paragraph (I)(3) of this rule.

Upon a report (verbal or written) of a change of address within the state of Ohio, the administrative agency must:
(1) Give or mail to the individual a notice meeting the voter registration requirements of section 3503.10 of the Revised Code, and advise the individual that, upon request, the administrative agency will help the individual register to vote or update voter registration as outlined in rule 5101:1-2-15 of the Administrative Code.

(2) Process an intercounty transfer (ICT) if the individual has changed residence from one county to another. Both the county of original residence and the county of new residence have responsibilities in the ICT process. The ICT process shall be followed whether the individual reporting a change of residence is an applicant or is currently in receipt of medical assistance benefits.
(a) The CDJFS receiving report of a move shall determine whether the move is a change of residence or a temporary absence from the home. If the move is a temporary absence
from the home, the county in which the individual is physically located shall provide necessary medical and transportation services.

(b) The CDJFS receiving report of a change of residence shall:

(i) Update the address in the electronic eligibility system. If the individual does not have an address in the new county, use the address of the administrative agency in the new county.

(ii) If the report was made to the administrative agency in the county of new residence, inform the county of original residence.

(c) The CDJFS in the county of original residence shall transfer the case in its current status in the electronic eligibility system within five working days of the reported change. If any case records or physical or electronic documents are maintained by the CDJFS outside of the electronic eligibility system, the CDJFS shall:

(i) Transfer the case records, or a physical or electronic copy of the records, to the county of new residence within fifteen days of the reported change. The case record to be transferred shall contain the original (or, if the administrative agency uses an imaging system, a scanned image) of the following documents:

(a) The most recently signed "Printed Copy of Information" (PCI) or application for medical assistance benefits; and

(b) Other pertinent documents, such as citizenship, income or resource verifications

(ii) Complete a notice of intercounty transfer, attach a copy of the notice to the records being transferred to the county of new residence, and keep a copy of the notice in the retained case record.

(iii) Maintain a copy of transferred documents for future reference, while providing original documents, to the extent available, to the county of new residence.

(d) The CDJFS in the county of new residence shall:

(i) Not require the individual reapply or cooperate with a redetermination of eligibility for medical assistance merely due to the change in county of residence.

(ii) Provide the medical assistance benefits for which the individual is eligible.

(iii) Perform the periodic redetermination or redetermination upon a change in circumstances as outlined in this rule.

(e) If the case being transferred is subject to a claim for overpayment as set out in rule 5101:1-38-20 of the Administrative Code:

(i) An existing claim shall not be transferred. The records transferred to the CDJFS in the county of new residence shall include copies of the documentation of the claim. The CDJFS establishing the claim remains responsible for any necessary action on the claim.

(ii) If no claim has been established and the CDJFS in each county agrees that the county of new residence shall establish the claim, then a potential claim may be transferred to the CDJFS in the county of new residence to be established by the CDJFS in that county.

(O) Distribution of informational materials. The administrative agency:

(1) Must distribute materials to individuals only in accordance with 42 C.F.R. 431.307 (as in effect on March 1, 2013).

(2) May distribute materials directly related to the health and welfare of applicants and beneficiaries, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.
Effective:
R.C. 119.032 review dates:
Certification Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011, 5111.012
Rule Amplifies: 5111.01, 5111.011, 5111.012, 329.051, 2913.401, 3501.01, 3503.10, 5101.58
MEMMTL 1

Effective Date: October 1, 2013

(A) This rule describes the administrative agency's responsibilities regarding disclosing information, maintaining confidentiality and safeguarding information for an individual applying for or participating in a medical assistance program.

(B) "Safeguarded information" includes but is not limited to the following types of information:

1. Names and addresses; and
2. Medical services provided; and
3. Social and economic conditions or circumstances; and
4. Agency evaluation of personal information; and
5. Medical data, including diagnosis and past history of disease or disability; and
6. Any information received in connection with the identification of third party coverage; and
7. Any information received for verifying income eligibility and amount of medical assistance payments. Income information received from the social security administration (SSA) or the internal revenue service (IRS) must be safeguarded according to the requirements of the agency that furnished the data.

(C) Administrative agency safeguarding responsibilities. The administrative agency must:

1. Implement administrative, physical and technical safeguards in accordance with 45 CFR 164.308, 45 CFR 164.310, and 45 CFR 164.312 (as in effect on April 1, 2013).
2. Follow the safeguarding guidelines for protecting federal tax information (FTI) described in the most current version of IRS publication 1075 (rev. 6/2010).
3. Safeguard information received or maintained about an individual connected with the administration of the medicaid program in accordance with 42 C.F.R. 431.302 (as in effect on March 1, 2013).
4. Publicize provisions governing the confidential nature of information about individuals, including the legal sanctions imposed for improper disclosure and use, in accordance with 42 C.F.R. 431.304 (as in effect March 1, 2013).
5. Provide copies of the publicized provisions to individuals and to other persons and agencies to whom information is disclosed, in accordance with 42 C.F.R. 431.304 (as in effect March 1, 2013).
6. Protect the types of safeguarded information required by 42 C.F.R. 431.305 (as in effect March 1, 2013).
7. Not release medical, psychiatric or psychological information to an individual or authorized representative if the administrative agency has reason to believe that the release may have an adverse effect on the individual, as provided in section 5122.31 of the Revised Code.
8. Not publish names of individuals in accordance with 42 C.F.R. 431.306(c) (as in effect March 1, 2013).

(D) Release of information. The administrative agency must:

1. Obtain permission from an individual or authorized representative before releasing information, unless that information is used to verify income or eligibility, in accordance with 42 C.F.R. 431.306(d) (as in effect on March 1, 2013).
Apply policies to all requests for information from outside sources, including governmental bodies, courts of law, or law enforcement officials, except as provided in sections 5101.26 to 5101.30 of the Revised Code.

Establish criteria specifying the conditions for release and use of information about individuals. The information must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the agency in accordance with 42 C.F.R. 431.306(a) and (b) (as in effect on March 1, 2013).

Limit disclosures of protected health information (PHI) for individuals applying for, or participating in, a medical assistance program to purposes related to payment, treatment, or health care operations. For any other purposes, disclosures of information about the health care of an individual, health care provided to an individual, or payment for the provision of health care for an individual require an authorization compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in accordance with 45 CFR 164.508 (as in effect April 1, 2013).

Release information as permitted by and in accordance with sections 5101.27 and 5101.271 of the Revised Code.

Effective:
R.C. 119.032 review dates:
Certification
Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011
Rule Amplifies: 307.981, 329.01, 1347, 3503.10, 5101.30, 5111.01, 5111.011, 5122.31, 5703.211
MEMMTL 1

Effective Date: October 1, 2013

(A) This rule sets out requirements for the administrative agency to identify and refer consumer fraud and erroneous payments made on behalf of an individual by Medicaid.

(B) Investigation of complaints. Upon notification of a complaint of Medicaid fraud, abuse or questionable practices, the administrative agency must conduct a preliminary investigation in accordance with 42 C.F.R. 455.14 (as in effect on April 1, 2013) to determine if there is sufficient basis to warrant a full investigation.

1. If the preliminary investigation finds that a full investigation is warranted in accordance with 42 C.F.R. 455.15 (as in effect on April 1, 2013):
   (a) And there is reason to believe that a beneficiary has defrauded the Medicaid program as described in section 2913.401 of the Revised Code, then the administrative agency must refer the case to the county prosecutor.
   (b) And there is reason to believe that a beneficiary has abused the Medicaid program, then the agency must conduct a full investigation of the abuse.

2. The investigation must continue until the investigation is resolved in accordance with 42 C.F.R. 455.16 (as in effect on April 1, 2013).

(C) Recovery of erroneous payments is authorized in section 5111.12 of the Revised Code, subject to rule 5101:9-7-06 of the Administrative Code. The administrative agency must:

1. Not attempt to recover erroneous payments when:
   (a) An individual would have remained eligible under another category of medical assistance even if the individual’s circumstances had been reported accurately or a change had been reported promptly; or
   (b) The erroneous payment was a result of an administrative error not caused by the individual.

2. Recover erroneous payments from an individual only:
   (a) Through reimbursement. Erroneous payments must not be recovered by reducing benefits or services to the individual.
   (b) From the responsible adult or guardian, if the erroneous payment was made on behalf of a child.
   (c) To the extent that an actual overpayment resulted. If an individual who reported a change within the ten-day reporting period would have remained eligible for a given month, after allowing a ten-day period to for the administrative agency to act on a change and allowing for the adverse action period, there is no overpayment in that month.

3. Send a notice of Medicaid overpayment to the individual.

(D) Amount subject to recovery. If the erroneous payment resulted from:

1. Fraud, as determined by a county prosecutor, the administrative agency must accept any reimbursement plan ordered by a court or agreed to by the county prosecutor.

2. Excess resources, the amount subject to recovery is the lesser of:
   (a) The amount of the payment made on behalf of the individual; or
   (b) The difference between the actual amount of countable resources and the applicable resource standard.
(3) Excess income, the amount subject to recovery is the total amount of payments made on behalf of the individual during the month or months of the erroneous payment period.

(4) For combinations of excess resources and excess income, the amount subject to recovery is the greater of either paragraph (D)(2) or paragraph (D)(3) of this rule.

(5) An incorrect spenddown amount, as calculated according to rule 5101:1-39-10 of the Administrative Code, the amount subject to recovery is the lesser of:

   (a) The total amount of payments made on behalf of the individual; or

   (b) The difference between the amount of the spenddown liability in effect during the erroneous period and the correct amount of the spenddown liability, added up over the months of the erroneous period.

(6) Receipt of long-term services and supports, waiver services, or intermediate care facility for the mentally retarded (ICF/MR) services, as a result of:

   (a) Improper transfer of resources as outlined in rule 5101:1-39-07 of the Administrative Code, the amount subject to recovery is the amount of payments made on behalf of the individual.

   (b) Resources in excess of the limit set forth in rule 5101:1-39-05 of the Administrative Code:

      (i) The amount subject to recovery is the difference between the actual amount of countable resources and the applicable resource standard.

      (ii) The individual may choose to increase the patient liability through payment of a lump sum to the nursing facility if the increase will reduce the resources to the appropriate limit. The reduction in resources must be accomplished in one calendar month and in compliance with rule 5101:1-38-01.8 of the Administrative Code.

   (c) Patient liability as outlined in of rule 5101:1-39-24 of the Administrative Code, the amount subject to recovery is the difference between the amount of the correct patient liability and the amount of the patient liability that was in effect during the erroneous payment period, added up over the months of the erroneous period.

(E) Individual responsibility. The individual must complete and return the notice of medicaid overpayment within thirty days from the date the form was sent by the administrative agency.

Effective:
R.C. 119.032 review dates:
Certification
Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011
Rule Amplifies: 2913.401, 5111.01, 5111.011, 5111.12
(A) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law requiring the administrative agency to issue a certificate of creditable coverage and a privacy notice.

(B) Administrative agency responsibilities: The administrative agency shall:

1. Ensure appropriate safeguards are taken in accordance with rule 5160:1-1-51.1 of the Administrative Code.

2. Issue all individuals of medical assistance programs a privacy notice, as described in 45 C.F.R. 164.520 (as in effect September 1, 2013), outlining the following descriptions of uses and disclosures, and procedures:

   a. A description of the types of uses and disclosures of PHI the administrative agency is permitted with examples for each of the following purposes:
      i. Payment;
      ii. Treatment; and
      iii. Healthcare operations.

   b. A description of uses and disclosures permitted without the individual's written consent or authorization;

   c. A statement that other uses and disclosures will be made only with the individual's written authorization;

   d. Complaint procedure;

   e. Request for restriction procedure;

   f. Request for amendment procedure;

   g. Request for accounting procedure; and

   h. A name, or title, and telephone number of a person to contact for further information.

3. Issue the JFS 03748, "Certificate of Group Health Plan Coverage" (rev. 11/2013) or its electronic equivalent, for any Medicaid eligible individual, as set forth in 45 C.F.R. 146.115 (as in effect September 1, 2013). The administrative agency may create its own certificate provided it contains all of the following information:

   a. The date the certificate is issued.

   b. The name of the group health plan that provided the coverage.

   c. The name(s) of the individual(s).

   d. The Medicaid identification number.

   e. The name, address and telephone number of the administrative agency member who is responsible for issuing certificates and accepting telephone inquiries regarding the certificates.

   f. A statement that an individual has at least eighteen months of creditable coverage before a significant break in coverage or, if less than eighteen months, the beginning date of creditable coverage.

   g. Date the creditable coverage ended.

   h. An educational statement regarding HIPAA explaining:
The restrictions on the ability of a health plan or issuer to impose a pre-existing condition exclusion against an individual including an individual's ability to reduce a pre-existing condition exclusion by creditable coverage;

Special enrollment rights;

The prohibitions against discrimination based on any health factor;

The right to individual health coverage;

The fact that state law may require issuers to provide additional protections to individuals; and

Where to get more information.

(4) Provide the certificate of coverage to all medicaid-eligible individuals, dependents or to an entity requesting the certificate on behalf of the individual. The certificate shall be available for up to no less than twenty-four months after coverage ceases.

(a) The certificate shall be mailed to the individual's last known address.

(b) If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address.

Replaces: 5160:1-2-01.5
Effective: 01/01/2014
R.C. 119.032 review dates: 01/01/2019
Certification: CERTIFIED ELECTRONICALLY
Date: 12/20/2013
Promulgated Under: 111.15
Statutory Authority: 5162.031, 5163.02
Rule Amplifies: 5162.031, 5163.02
Prior Effective Dates: 10/1/98, 10/6/03, 11/1/09
MEMMTL 4

(A) This rule describes the administrative agency’s role in facilitating outreach services for low-income children and pregnant women through the process of outstationing workers at disproportionate share hospitals and federally qualified health centers.

(B) Responsibilities of the administrative agency.

(1) Locations. The administrative agency:

(a) Must establish and staff outstation locations at each disproportionate share hospital and each federally-qualified health center participating in the medicaid program and providing services to medicaid-eligible children and pregnant women.

(b) May establish additional outstation locations at any other site where potentially eligible children or pregnant women receive services. These additional sites may include additional sites other than the main outstation location of federally-qualified health centers or disproportionate share hospitals.

(2) Hours.

(a) Workers must be available at each outstation location during the administrative agency’s regular office operating hours to accept applications and to assist applicants with the application process.

(b) If the administrative agency determines that an outstation site is infrequently used and does not require a full-time outstationed worker, a notice must be displayed:

(i) Containing the following information:

(a) The hours when an outstationed worker will be available; and

(b) The telephone number of the administrative agency that individuals may call for assistance.

(ii) Providing adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

(3) Workers and assistance.

(a) The agency may use county employees, provider or contractor employees, or volunteers who have been properly trained to staff outstation locations under the following conditions:

(i) County outstation intake workers may perform all eligibility processing functions, including the eligibility determination, if the worker is authorized to do so at the regular intake office.

(ii) Provider or contractor employees and volunteers may perform only initial processing functions. Provider and contractor employees and volunteers are subject to:

(a) The confidentiality of information rules specified in 42 C.F.R. part 431, subpart F (as in effect on December 31, 2013);

(b) The requirements of 42 C.F.R. section 447.10 (as in effect on December 31, 2013), which prohibit medicaid payments to anyone other than a provider or recipient except under specific circumstances; and

(c) All other Ohio or federal laws concerning conflicts of interest.
The outstationed worker must:

(i) Complete the initial processing of the application for medical assistance.

(a) When authorized by the administrative agency, the outstationed worker may also determine medicaid eligibility.

(b) If the outstationed worker is only performing initial processing duties, the outstationed worker must forward the application to the administrative agency in accordance with Chapter 5160:1-1 and Chapter 5160:1-2 of the Administrative Code.

(ii) Accept and refer applications for other public assistance programs to the administrative agency for processing.

Replaces: 5160:1-2-04
Effective: 01/01/2014
R.C. 119.032 review dates: 01/01/2019
Certification: CERTIFIED ELECTRONICALLY
Date: 12/20/2013
Promulgated Under: 111.15
Statutory Authority: 5162.031, 5163.02
Rule Amplifies: 5163.02, 5163.10, 5163.101
Prior Effective Dates: 5/1/95, 7/1/00, 1/1/06
MEMM 1

Effective Date: October 1, 2013

(A) This rule describes the responsibilities of an individual applying for or receiving medical assistance, whether on behalf of the individual or someone else.

(B) Individual responsibilities.

(1) When applying for or receiving any medical assistance, an individual must:

   (a) Sign and submit an initial application under penalty of perjury. This signature may be electronic, telephonic, a copy or facsimile, or an original ink signature.

   (b) Cooperate with the administrative agency in application, verification, determination, redetermination, auditing, and quality control processes set out in this chapter of the Administrative Code. The individual must:

      (i) Answer all relevant questions and provide information and documentation necessary to verify the conditions of eligibility as described in rule 5101:1-37-58 of the Administrative Code and the requirements specific to the relevant eligibility category in order to establish initial or continued eligibility.

      (ii) Request assistance from the administrative agency when unable to obtain requested information. The individual must provide the information necessary to allow the administrative agency to assist the individual.

   (c) Select a managed care plan (MCP) as required by rule 5101:3-26-02 of the Administrative Code, unless the individual meets one of the exceptions listed in that rule.

   (d) Inform the administrative agency within ten days of any change to the following circumstances for the individual or any person living with the individual:

      (i) Address.

      (ii) Marital status.

      (iii) Income, including:

              (a) One-time gifts or payments, and

              (b) A change in hourly wage or salary, full- or part-time status, new employment, or loss of employment.

      (iv) An individual's pregnancy status, such as an individual becoming pregnant or a pregnancy ending.

      (v) Third-party responsibility for the individual's health care costs, including:

              (a) New coverage under a health insurance policy, no matter who is paying for the coverage;

              (b) A change in health insurers;

              (c) Loss or ending of other health insurance coverage;

              (d) A court order requiring a person or entity to pay some or all of the individual's medical expenses; or

              (e) Any accident or injury for which another person or entity may be responsible, such as a work-related injury or an injury received in an automobile collision. In addition to reporting the injury or accident, an individual must also report any information received about any involved insurance company.
Cooperate with any third party responsible for an individual's health care costs.

Not commit medicaid eligibility fraud as described in section 2913.401 of the Revised Code.

When applying for or receiving medical assistance on the basis of being blind, disabled, or at least age sixty-five, an individual must also inform the administrative agency of any:

(a) Improvement of the condition for which the benefit is received; or

(b) Change in the ownership or value of a resource owned by the individual or the individual's spouse, including any change in an annuity or an annuity's remainder beneficiary designation.

(C) Authorized representative.

(1) An authorized representative may be any person at least eighteen years old, or a business or other legal entity.

(2) An authorized representative must be appointed by an individual to act on the individual's behalf or have access to the individual's medicaid information.

(a) The document appointing an authorized representative must:

(i) Identify what duties the individual is authorizing the representative to perform, and

(ii) Be signed by the individual.

(b) The individual may contact the administrative agency to remove an authorized representative or reduce the authorized representative's authority in person, in writing, or by telephone.

(c) If an individual is unable to identify an authorized representative because of incapacity or incompetence, the administrative agency will assist the individual with appointing an authorized representative, as described in rule 5101:1-37-51 of the Administrative Code.

(3) The administrative agency must request proper identification from the authorized representative prior to disclosure of medicaid information to or representation of the individual by the authorized representative.

(4) All notices and correspondence sent to an individual by the administrative agency will also be sent to the authorized representative.

(5) The administrative agency may contact an individual to clarify or verify information provided by an authorized representative if the authorized representative provides information that seems contradictory, unclear, or unrealistic.

Effective:
R.C. 119.032 review dates:
Certification
Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 111.011, 5111.012
Rule Amplifies: 5111.01, 5111.011, 5111.012, 5101.58, 329.051
MEMMTL 2

**Effective Date: October 1, 2013**

(A) This rule describes the responsibilities of an authorized representative who is appointed in writing by the individual to stand in the place of the individual and act with authority on behalf of the individual. These responsibilities do not apply to people or organizations who merely help or assist an individual with portions of the application, verification, or redetermination process, unless the individual or organization is granted authority to act on behalf of the individual.

(B) Assistance from individuals who are not authorized representatives. A person may accompany and assist an individual without being an individual's authorized representative.

1. The administrative agency must not reveal safeguarded information, as described in rule 5101:1-37-51.1 of the Administrative Code, or send notices or correspondence to a person who is assisting an individual, unless the person is designated in writing as an authorized representative.

2. A person who is assisting an individual must provide accurate information, to the best of his or her knowledge, regardless of whether the person is an authorized representative.

(C) Appointment of an authorized representative.

1. Any person at least eighteen years old, or a business or other legal entity, may be appointed an authorized representative by an individual.

2. An authorized representative must be appointed by an individual in order to act on the individual's behalf or have access to the individual's medicaid information. The document appointing an authorized representative must identify what duties the individual is authorizing the representative to perform.

3. If the appointed authorized representative is unwilling or unable to accept the responsibility of being an authorized representative, the authorized representative must inform the administrative agency and the individual of the refusal or withdrawal.

(D) Responsibilities of an authorized representative. If a person or organization is designated as an individual's authorized representative, the authorized representative:

1. Must present proper identification, if requested by the administrative agency, prior to representation of the individual by or disclosure of medicaid information to the authorized representative.

2. Will receive copies of notices and correspondence sent to the individual by the administrative agency.

3. Stands in the place of the individual. Any responsibility of the individual is a responsibility of the authorized representative. Any action taken by the authorized representative or failure to act will be accepted as the action or lack of action of the individual.


(E) The administrative agency may contact the individual to clarify or verify information provided by an authorized representative if the authorized representative provides information that seems contradictory, unclear, or unrealistic.

Effective:

R.C. 119.032 review dates:

Certification

Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011, 5111.012
Rule Amplifies: 5111.01, 5111.011, 5111.012, 2913.401, 3501.01, 3503.10, 5101.58, 329.051
MEMMTL 1
Effective Date: October 1, 2013

(A)  This rule describes eligibility criteria that apply to all medical assistance programs, how eligibility
criteria will be verified by the administrative agency, and when an individual will be asked to provide
manual verification. Eligibility conditions that are specific to a certain eligibility group are addressed in
the eligibility rule for that group.

(B)  To be determined eligible for medical assistance, an individual must:

(1)  Provide a social security number (SSN) in accordance with 42 C.F.R. 435.910 (as in effect
September 1, 2013).

   (a)  The individual's self-declaration of SSN meets this condition unless contradictory
information is provided to or maintained by the administrative agency.

   (b)  An individual is not required to provide a SSN if the individual:

          (i)  Is applying for or receiving alien emergency medical assistance (AEMA).

          (ii) Refuses to obtain a SSN because of well-established religious objections. Well-
               established religious objections exist when the individual:

                 (a)  Is a member of a recognized religious sect or division of the sect, and

                 (b)  Adheres to the tenets or teachings of the sect or division of the sect and for
                     that reason is conscientiously opposed to applying for or using a national
                     identification number.

   (c)  If the individual has not been issued or cannot recall the individual's SSN, the
administrative agency must assist the individual in obtaining or applying for the
individual's SSN.

(2)  Be a resident, as defined in 42 C.F.R. 435.403 (as in effect April 1, 2013) of the state of Ohio on
the date of application or requested coverage begin date.

   (a)  The individual's self-declaration of residency meets this condition unless contradictory
information is provided to or maintained by the administrative agency.

   (b)  An individual remains a resident despite a temporary absence from the state if the
individual intends to return when the purpose of the absence has been accomplished,
unless another state has determined that the individual is a resident there for purposes of
medicaid eligibility.

   (c)  The individual must not be eligible for and receiving medical assistance in another state
or U.S. territory. An individual who has recently become an Ohio resident is not ineligible
for medical assistance merely due to processing delays in terminating medical assistance
in the prior state of residence.

(3)  Be a U.S. citizen or qualified alien.

   (a)  An individual is not required to declare or verify citizenship or alien status when the
individual is applying for benefits only on behalf of another person.

   (b)  An individual's declaration of U.S. citizenship must be verified as described in rule

   (c)  An individual's declaration of qualified non-citizen status must be verified as described in
rule 5101:1-37-58.3 of the Administrative Code. Verification of alien status is not required
when the individual is applying for AEMA.
(4) Take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits for which the individual is eligible, unless the individual can show good cause for not doing so, in accordance with 42 CFR 435.608 (as in effect on April 1, 2013).

(a) "Good cause", for the purposes of paragraph (B)(4) of this rule, means that to obtain a benefit, the individual would incur any significant disadvantage or detriment, including but not limited to any significant cost or expense.

(b) Benefits that the individual must take steps to obtain include but are not limited to annuities, retirement, veterans benefits, supplemental security income (SSI), social security disability income (SSDI), railroad retirement, and unemployment compensation.

(c) If eligibility or ineligibility for other benefits cannot be verified electronically, an official letter from the paying entity or financial institution is sufficient to verify the benefit.

(5) In accordance with 42 CFR 435.610 (as in effect on April 1, 2013), assign to the state of Ohio any rights to medical support and payments for medical care from any third party for:

(a) The individual, and

(b) Any medicaid-eligible individual for whom the individual is legally able to make an assignment.

(6) Cooperate with the child support enforcement agency (CSEA) in establishing the paternity of any medicaid eligible child, in accordance with 42 C.F.R. 433.147 (as in effect on April 1, 2013), unless the individual:

(a) Is not receiving medical assistance for himself or herself;

(b) Is a pregnant woman, including her sixty day post-partum period;

(c) Provides good cause as determined by the local CSEA; or

(d) Is receiving transitional medical assistance.

(7) Cooperate with the administrative agency in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. To meet this condition, the individual must provide the name of the insurance company, billing address, subscriber identification number, group number, name of policy holder, and a list of covered individuals. In addition, the individual must cooperate with requests:

(a) From a third-party insurance company to provide additional information that is required to authorize coverage or obtain benefits through the third party insurance company.

(b) From a medicaid provider, managed care plan, or a managed care plan's contracted provider to provide additional information that is required for the provider or plan to obtain payments from a third-party insurance company for medicaid covered services.

(c) From a third-party insurance company, medicaid provider, managed care plan, or a managed care plan's contracted provider to forward or return to the third-party insurance company for medicaid covered services when:

(i) The provider has billed the third-party insurance company for medicaid covered services provided to the individual, and

(ii) The third-party insurance company has sent payment to the individual for medicaid covered services the individual received from the provider.

(8) Meet all eligibility requirements for an eligibility category set out in an approved state plan amendment, Chapter 5101:1-37, 5101:1-39, 5101:1-41 or 5101:1-42 of the Administrative Code, including:

(a) Income requirements for the eligibility category.
If an individual's declared income exceeds the relevant federal poverty level (FPL) threshold, the individual's declared income will be accepted without further verification.

If an individual's declared income is reasonably compatible with data available through an electronic data source, the individual's declared income will be accepted without further verification.

If the administrative agency is unable to verify income through an electronic data source, acceptable verification documentation includes, but is not limited to:

(a) Information maintained as a regular part of business by a government entity;
(b) A current pay stub;
(c) An award letter from a certifying agency;
(d) IRS form 1099 or other tax documents; or
(e) Employer statement including hourly or salary wage, hours worked per pay period, length of pay period and any tax withholdings.

Resource and asset requirements for the eligibility category. If the administrative agency is unable to verify the value of an individual's resources through an electronic data source, acceptable verification documentation includes, but is not limited to:

(i) Information maintained as a regular part of business by a government entity;
(ii) A financial institution statement; or
(iii) Legal documents.

Effective:

R.C. 119.032 review dates:
Certification
Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011, 5111.02
Rule Amplifies: 5111.01, 5111.011, 5111.02
5160:1-1-58.1 Medicaid: Restrictions on Payment for Services

*Formerly* 5101:1-37-58.1 Medicaid: Restrictions on Payment for Services

**MEMMTL 1**

**Effective Date: October 1, 2013**

(A) Medicaid will not pay for services provided under the conditions set out in this rule, even if an individual has been found eligible for a medical assistance category and is enrolled in medicaid.

(B) As required by 42 C.F.R. 435.1009 (as in effect on May 1, 2013), medicaid will not pay for services provided while an individual:

1. Is confined in a public institution; or
2. Is a patient in an institution for mental diseases (IMD) who is age twenty-two or older, but under age sixty-five.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 111.15

Statutory Authority: 5111.01, 5111.011

Rule Amplifies: 5111.01, 5111.011, 5111.0119
MEMMTL 2

Effective Date: October 1, 2013

(A) This rule sets forth acceptable documentary evidence of United States (U.S.) citizenship and the circumstances under which an individual who declares U.S. citizenship, under penalty of perjury, may be given a reasonable opportunity to verify U.S. citizenship.

(B) Any individual applying for medical assistance and declaring U.S. citizenship or nationality shall verify citizenship in accordance with 42 C.F.R. 435.407 (as in effect on September 1, 2013).

(1) After an individual's U.S. citizenship or nationality is verified by the administrative agency, the administrative agency shall not require the individual to re-verify citizenship.

(2) The following individuals are not required to verify their U.S. citizenship:

(a) An individual applying for medical assistance only for other individuals.

(b) A child who received medicaid as a deemed newborn on or after July 1, 2006.

(c) An individual who is:

(i) Enrolled in medicare;

(ii) Receiving supplemental security income (SSI);

(iii) Receiving social security disability insurance (SSDI);

(iv) Receiving adoption or foster care assistance under Title IV-E of the Social Security Act (as in effect on September 1, 2013); or

(v) In foster care and receiving child welfare services under Title IV-B of the Social Security Act.

(d) Other individuals on such other basis as the secretary of the department of health and human services may specify, by regulation, that satisfactory documentary evidence of citizenship or nationality was previously presented.

(e) The administrative agency may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal agency or another state agency, if such verification was done on or after July 1, 2006.

(C) If the administrative agency is unable to verify an individual's citizenship through the social security administration (SSA) or department of homeland security (DHS) electronic data exchange in the electronic eligibility system, the following documents must be accepted as satisfactory documentary evidence of citizenship:

(1) A U.S. passport, unless it was issued with a limitation; limited passports are issued through the department of homeland security (DHS) using form I-131. A passport does not have to be currently valid unless it was issued to an individual born in Puerto Rico;

(2) A certificate of naturalization (DHS form N-550 or N-570);

(3) A certificate of U.S. citizenship (DHS form N-560 or N-561);

(4) A valid state-issued driver's license, if the state issuing the license requires proof of U.S. citizenship before issuance of such license or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the individual, who is a citizen;

(5) Native American tribal documents, including, but not limited to:

(a) A Seneca Indian tribal census record;
(b) The bureau of Indian affairs tribal census records of the Navajo Indians;
(c) A certificate of Indian blood;
(d) U.S. American Indian or Alaska native tribal document; or
(e) Other native American tribal documents.

(6) Such other documents as the secretary of the department of health and human services may specify, by regulation, provide proof of U.S. citizenship or nationality and that provide a reliable means of personal identity.

(D) If none of the documents from paragraph (C) of this rule are available, the administrative agency shall verify U.S. citizenship using a combination of one birth or nationality document from paragraph (D)(1) of this rule and one identity document from paragraph (D)(2) of this rule. Although some documents may be listed as both birth and nationality documents and identity documents, a particular document may only be used to satisfy either birth and nationality or identity, not both. A birth or nationality document or an identity document alone does not satisfy the citizenship documentation requirement.

(1) Birth or nationality shall be documented using an item from the following hierarchical list:

(a) A U.S. public birth record or birth document, showing birth in one of the fifty states, the District of Columbia, American Samoa, Guam (on or after April 10, 1899), the Northern Mariana Islands (NMI) (after November 4, 1986 NMI local time), Puerto Rico (on or after January 13, 1941), Swain's Island, or the U.S. Virgin Islands (on or after January 17, 1917) and for individuals whose U.S. citizenship may be established for collectively naturalized individuals as designated, by regulation, from the secretary of the department of health and human services. A birth certificate issued by Puerto Rico is valid only if it was issued on or after July 1, 2010;

(b) Birth information obtained through the administrative agency's data exchanges, as authorized by federal regulation or guidance from the secretary of the department of health and human services;

(c) A certification of birth abroad issued by the department of state (DS-1350);

(d) A certification of birth abroad (FS-545);

(e) A U.S. citizen identification card (I-197 or I-179);

(f) A report of birth abroad of a citizen of the U.S. (FS-240);

(g) A Northern Mariana Islands identification card (I-873), issued by the United States citizen and immigration service (USCIS), to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 3, 1986;

(h) A final adoption decree or a statement from a state-approved adoption agency showing the individual's name and U.S. place of birth. In situations in which the adoption is not finalized and the state will not release a birth certificate prior to a final adoption decree, a statement showing the individual's name and U.S. place of birth, and stating that the source of information regarding the place of birth is an original birth certificate;

(i) Evidence of civil service employment by the U.S. government prior to June 1, 1976;

(j) An official military record of service showing a U.S. place of birth;

(k) A data verification with the systematic alien verification for entitlements (SAVE) program for naturalized citizens, including but not limited to the provision of the individual's alien registration number;

(l) Evidence showing an individual meets the requirements of the Child Citizenship Act of 2000, Pub. L. No. 106-395 (October 30, 2000). The administrative agency must obtain documentary evidence verifying that at any time on or after February 27, 2001, the following conditions have been met:

(i) At least one parent of the child is a U.S. citizen by either birth or naturalization;
(ii) The child is under the age of eighteen years;
(iii) The child is residing in the United States in legal and physical custody of the U.S. citizen parent;
(iv) The child was admitted to the U.S. for lawful permanent residence, as verified under the requirements of 8 U.S.C. 1641 as in effect on July 13, 2007 pertaining to verification of qualified alien status; and
(v) If adopted, the child satisfies the requirements of section 101 (b)(1) of the Immigration and Nationality Act pertaining to international adoptions, as in effect on July 13, 2007 including:
    (a) Admission for lawful permanent residence as a child adopted outside the U.S. (IR-3); or
    (b) Admission for lawful permanent residence as a child coming to the U.S. to be adopted, with final adoption having subsequently occurred (IR-4);

(m) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth;
(n) A life insurance, health insurance, or other insurance record showing a U.S. place of birth;
(o) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.;
(p) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth;
(q) A federal or state census record showing U.S. citizenship or a U.S. place of birth, including the individual's age;
(r) Affidavits made under penalty of perjury. The affidavits do not need to be notarized. Affidavits may be used only in rare circumstances when the administrative agency is unable to secure evidence of birth or nationality from another listing. If the documentation requirement needs to be met through affidavits, the affidavit must be signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and contain the applicant's name, date of birth, and place of U.S. birth.
(s) Such other documents as the secretary of the department of health and human services may specify, by regulation, that provide proof of U.S. citizenship or nationality.

(2) One of the following identity documents shall be used in combination with a birth or nationality document listed in paragraph (D)(1) of this rule. A document used to verify birth or nationality may not also be used to verify identity, even if the document is listed below.
    (a) A driver's license or similar document issued for the purpose of identification by a state, if it contains a photograph of the individual or such other personal identifying information relating to the individual, such as: name, date of birth, gender, height, eye color and address;
    (b) An identification card issued by federal, state, or local government agencies or entities, provided it contains a photograph or other information such as: name, date of birth, gender, height, eye color and address:
        (i) A U.S. military card or draft record;
        (ii) A military dependent's identification card;
        (iii) A U.S. coast guard merchant mariner card; or
        (iv) A school identification card with a photograph;
For children under age nineteen, a clinic, doctor, hospital or school record, including preschool or day care records;

Two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees and property deeds or titles;

If the individual does not have any document specified in paragraphs (D)(2)(a) to (D)(2)(d) of this rule, the individual may submit an affidavit signed under penalty of perjury by another person who can reasonably attest to the individual's identity. Such affidavit must contain the individual's name and other identifying information establishing identity, such as date of birth, gender, height, eye color and address. The affidavit does not have to be notarized; or

Such other documents of personal identity as the secretary of the department of health and human services finds, by regulation, provide reliable means of identification.

Reasonable opportunity period. If the administrative agency is unable to verify U.S. citizenship through the social security administration (SSA) electronic state verification and exchange system (SVES), and the individual has not provided satisfactory documentation as described in paragraphs (C) and (D) of this rule, the administrative agency shall give the individual reasonable opportunity to present satisfactory documentation of U.S. citizenship.

1. The administrative agency shall approve time-limited medical assistance, provided the individual satisfies all other conditions of eligibility outlined in rule 5101:1-37-58 of the Administrative Code. The reasonable opportunity period:

   (a) Begins on the date of the individual's application.

   (b) Ends ninety-five days after the administrative agency provides the individual (in person, electronically, or by mail) with the notice of the reasonable opportunity period.

2. If, by the end of the reasonable opportunity period, the individual's citizenship or immigration status has not been verified, the administrative agency must take action within thirty days to terminate eligibility.

Effective:
R.C. 119.032 review dates:
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Statutory Authority: 5111.01, 5111.011, 5111.02
Rule Amplifies: 5111.01, 5111.011, 5111.02
MEMMTL 2

Effective Date: October 1, 2013

(A) This rule sets forth medicaid eligibility criteria for an individual who is not a U.S. citizen or national, acceptable documentary evidence of qualified non-citizen status, and the circumstances under which an individual who declares qualified non-citizen status, under penalty of perjury, may be given a reasonable opportunity to verify that status.

(B) Definitions. For the purposes of this rule:

(1) "A-number" means the alien registration number issued to a non-citizen by the United States citizenship and immigration service (USCIS) or, in limited circumstances, by the United States department of state.

(2) "Active duty" means full-time employment in the military service, and does not include reserve or guard duty. The service member shall serve a minimum of twenty-four months or the period for which the person was called to military service in order to be eligible for benefits that are based on the length of active duty service.

(3) "Amerasian" means an alien born in Cambodia, Korea, Laos, Thailand, or Vietnam after December 31, 1950, and before October 22, 1982, who was fathered by a U.S. citizen.

(4) "Asylee" means a person who has been granted asylum under section 208 of the Immigration and Nationality Act (INA) (as in effect on September 1, 2009).

(5) "Child" means an individual under the age of twenty-one.

(6) "Indefinite detainee" means a non-citizen who has served time for a criminal conviction and has received a final order of removal, but remains indefinitely in the United States because neither the individual's home country nor any other country will accept the individual. Being an indefinite detainee does not confer medicaid eligibility upon an individual nor does it serve as an exemption to the five-year bar described in paragraph (C) of this rule.

(7) "Lawful permanent resident" (LPR) means an individual who has been granted the privilege of living permanently in the United States as an immigrant.

(8) "Parolee" means a person who has been given permission by the United States department of justice or the United States department of homeland security to enter the United States in an emergency or because it serves an overriding public interest. Parolees are granted temporary residence and are not on a predetermined path to permanent resident status.

(9) "Qualified alien" means:

(a) An LPR;

(b) An asylee;

(c) A refugee admitted to the United States under section 207 of the INA (as in effect on September 1, 2009);

(d) A parolee allowed into the United States under section 212(d)(5) of the INA (as in effect on September 1, 2009) for a period of at least one year;

(e) An alien whose deportation is being withheld under section 243(h) or 241(b)(3) of the INA (as in effect on September 1, 2009);

(f) An individual granted conditional entry pursuant to section 203(a)(7) of the INA (as in effect prior to April 1, 1980);

(g) A Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980;
(h) An Amerasian immigrant;

(i) An alien or alien's child who has been battered or subjected to extreme cruelty, as defined in 8 U.S.C. 1641(c) (as in effect on September 1, 2009); or


(10) "Quarter of coverage." is the basic unit for determining whether a worker is insured under the social security program. The amount of wages and self-employment income which an individual shall have in order to be credited with a quarter of coverage is defined in 42 U.S.C. 413(d) (as in effect on September 1, 2013), and is published annually in the Federal Register.

(11) "Veteran" means an individual who served in the active military service and who was discharged or released from duty under honorable conditions. This term includes military personnel who die during active duty service, as defined in 38 U.S.C. 1101 (as in effect on September 1, 2009), and Filipinos described in 38 U.S.C. 107 (as in effect on September 1, 2009). These are individuals who served in the Philippine Commonwealth army during World War II or as Philippine scouts following the war.

(12) "Victim of trafficking."

(a) Victims of trafficking and certain family members, as identified in the Trafficking Victims Protection Reauthorization Act of 2003 (TVPRA) (Pub. L. No. 108-193), are eligible for federally funded or administered benefits to the same extent as refugees, per 22 U.S.C. 7105(b)(1)(A) (as in effect on September 1, 2009).

(b) Victims of trafficking are awarded a certification letter from the office of refugee resettlement (ORR) and are potentially eligible for medicaid. Certain family members are awarded "Derivative T" visas and are potentially eligible for medicaid.

(i) ORR makes the certification determinations and issues letters of certification for adult victims of trafficking.

(ii) Victims of trafficking who are younger than eighteen years of age do not need to be certified in order to receive benefits. Instead, ORR issues notarized letters similar to adult certification letters, stating the child is a victim of trafficking.

(c) A victim of trafficking is not required to provide any other documentation of immigration status to receive benefits, unless the victim's immigration status has changed.

(C) An individual who is not a U.S. citizen or national must be in a satisfactory immigration status to be eligible for medical assistance.

(1) An alien who was lawfully residing in the United States as of August 22, 1996, and continues to be a lawful resident of the U.S. shall be considered to be in a satisfactory immigration status.

(2) A non-citizen who was granted qualified non-citizen status on or after August 22, 1996, does not have a satisfactory immigration status for medicaid for a period of five years beginning on the date the status was granted, unless the individual is one of the following:

(a) An individual whose immigration status meets any of the following criteria:

(i) Refugee;

(ii) Asylee;

(iii) An alien whose deportation is being withheld under section 243(h) of the INA (as in effect on September 1, 2009);

(iv) Cuban or Haitian entrant;

(v) Amerasian immigrant;

(vi) Victim of trafficking; or
(vii) An Afghan or Iraqi special immigrant.

(b) A lawfully residing pregnant woman.

(c) A lawfully residing child.

(d) An LPR who has forty quarters of coverage under Title II of the Social Security Act (as in effect on September 1, 2013) or can be credited with such quarters.

(i) In determining the number of quarters of coverage, an alien shall be credited as follows:

(a) All of the qualifying quarters of coverage worked by a natural or adoptive parent of such alien before the date the individual attains age eighteen can be credited;

(b) All of the qualifying quarters worked by a spouse of such alien during their marriage shall be credited so long as the alien remains married to such spouse or such spouse is deceased.

(c) A parent or spouse whose quarters are credited to the alien must be a U.S. citizen or an LPR.

(ii) A qualifying quarter does not include any quarter after December 31, 1996, in which the individual also received a federal means-tested public benefit.

(e) An individual who:

(i) Is a military member on active duty (other than active duty for training) in the armed forces of the United States; or

(ii) Is a veteran who received an honorable discharge, not a discharge on account of alienage as described in 8 U.S.C. 1426 (as in effect on September 1, 2009).

(f) A spouse or unmarried dependent child of a veteran or active duty service member as described in paragraph (C)(2)(e) of this rule.

(g) The surviving spouse of a deceased veteran or service member, provided the spouse has not remarried and the marriage fulfills the following requirements:

(i) Married for at least one year; or

(ii) Married before the end of a fifteen-year time span following the end of the period of military service in which the injury or disease was incurred or aggravated; or

(iii) Married for any period if a child was born of or before the marriage.

(h) An American Indian born in Canada to whom the provisions of 8 U.S.C. 1359 (as in effect on September 1, 2009) apply.

(i) A member of an Indian tribe, as defined in 25 U.S.C. 450B(e) (as in effect on September 1, 2009).

(3) An indefinite detainee is in a satisfactory immigration status only if the individual was in a satisfactory immigration status when the individual became an indefinite detainee.

(D) An individual who is not a U.S. citizen or national and not in a satisfactory immigration status may be eligible for alien emergency medical assistance as described in rule 5101:1-41-20 of the Administrative Code, and is not required to verify alien status.

(E) Any individual applying for medical assistance and declaring a satisfactory immigrant status shall verify his or her immigration status.

(1) The administrative agency must attempt to verify an individual's immigrant status through the SAVE program using the electronic eligibility system. There are two methods of verifying the immigration documents provided by the individual:
Primary verification through the SAVE program is an electronic verification of alien status provided within seconds of inquiry. This verification is used for most applicants.

Secondary verification through the SAVE program is used when the electronic eligibility system is unable to electronically verify alien status.

If the individual's immigrant status cannot be verified through the SAVE program, the following documents must be accepted as satisfactory documentary evidence of immigrant status:

(a) I-94 (arrival/departure record).
(b) I-551 (permanent resident card).
(c) Visa in passport with a stamp from the appropriate issuing agency showing immigration status.
(d) For victims of trafficking:
   (i) The original certification letter or letter for children from ORR is to be used in place of immigration documentation from USCIS. Retain a copy in the case file. Victims of trafficking are not required to provide any other immigration documents to receive benefits.
   (ii) The systematic alien verification for eligibility (SAVE) program does not contain information about victims of trafficking.
(e) Other documentation as prescribed or allowed by federal law.
(f) An indefinite detainee most likely will not have documentation of original immigration status, and should instead present the following documentation, available from ORR:
   (i) I-220B (order of supervision), which must include the alien's A-number and notation concerning exclusion, deportation or removal; or
   (ii) I-766, I-688A or I-688B (employment authorization documents), which must show either 8 C.F.R. 274a.12(c)(18) or 8 U.S.C. 1231(a)(7) (as in effect on September 1, 2009) as the provision of law authorizing employment.

When the individual's eligibility is based upon the veteran status of the individual, the individual's parent, or the individual's spouse, veteran status is verified by viewing an original or a certified copy of the DD Form 214 (undated).

Reasonable opportunity period. If the administrative agency has been unable to verify U.S. citizenship through the SAVE program, and the individual has not provided verification as described in paragraph (E)(2) of this rule, the administrative agency shall give the individual reasonable opportunity to present verification of satisfactory immigration status.

(1) The administrative agency shall approve time-limited medical assistance, provided the individual satisfies all other conditions of eligibility outlined in rule 5101:1-37-58 of the Administrative Code.

(2) The reasonable opportunity period:
   (a) Begins on the date of the individual's application.
   (b) Ends ninety-five days after the administrative agency provides the individual (in person, electronically, or by mail) with the notice of the reasonable opportunity period.

(3) If, by the end of the reasonable opportunity period, the individual's immigration status has not been verified, the administrative agency must take action within thirty days to terminate eligibility.

Effective:
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Rule Amplifies: 5111.01, 5111.011
This rule describes how an individual's or household's income is calculated under 42 C.F.R. 435.603 (as in effect on September 1, 2013) when determining an individual's eligibility for applications for medical assistance filed on or after January 1, 2014. This rule does not apply to determinations for categories of eligibility:

(1) For which an individual must be at least age sixty-five; or
(2) For which an individual must be found to be blind or disabled; or
(3) For which an individual must be found in need of long-term care services, whether in a facility or in a community setting; or
(4) Which cover only an individual's medicare premium or cost-sharing.

Definition. "Person", for the purpose of this rule, means someone in the family or household of an individual applying for or receiving medical assistance.

Determining household composition and family size.

(1) For each individual, the administrative agency must follow the requirements and definitions set out to determine household composition and family size. For the tax year in which the eligibility determination is being made:

(a) If an individual expects to file a tax return and does not expect to be claimed as a tax dependent, the household composition is determined under 42 C.F.R. 435.603(f)(1) (as in effect on September 1, 2013).

(b) If an individual expects to be claimed as a tax dependent, the household composition is determined under 42 C.F.R. 435.603(f)(2) (as in effect on September 1, 2013) unless the individual meets one of the exceptions set out in the subparagraphs of that section.

(c) Household composition is determined under 42 C.F.R. 435.603(f)(3) (as in effect on September 1, 2013) if the individual:

(i) Does not expect to file taxes or to be claimed as a tax dependent, or if it is unclear whether the individual will be claimed as a tax dependent; or

(ii) Meets one of the exceptions set out in a subparagraph of 42 C.F.R. 435.603(f)(2) (as in effect on September 1, 2013).

(2) When determining the family size of a household containing at least one pregnant woman, each pregnant woman is counted as herself plus:

(a) One; or

(b) The number of verified fetuses, if a doctor or nurse has provided a statement verifying a woman's pregnancy, including the expected date of confinement and the number of unborn fetuses.

(3) When determining the household of a married couple who live together, each spouse will always be considered a part of the other spouse's household, regardless of tax filing status and regardless of whether either spouse is claimed as a tax dependent.

Determining household income.

(1) The administrative agency must follow the requirements and definitions set forth in 42 C.F.R. 435.603 (as in effect on September 1, 2013) to determine the MAGI-based income, as set forth in 42 C.F.R. 435.603(e) (as in effect on September 1, 2013) of:
(a) The individual, and
(b) Each person in the individual's household.

(2) The individual's household income is the sum of the individual's MAGI-based income plus the MAGI-based income of each person in the individual's household, excluding only income from an individual who is:

(a) Included in the household of his or her natural, adopted or step parent; and
(b) Not expected to be required to file a tax return under section 6012(a)(1) of the Internal Revenue Code (as in effect on September 1, 2013) for the taxable year in which eligibility for medical assistance is being determined, whether or not the individual files a tax return.

(3) Before comparing an individual's household income to the highest income standard under which the individual may be determined eligible using MAGI-based methodologies, deduct a dollar amount equal to five per cent of the federal poverty level (FPL) for the individual's family size.

Effective:
R.C. 119.032 review dates:
Certification
Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011
Rule Amplifies: 5111.01, 5111.011, 5111.012
MEMMTL 6

Effective Date: April 25, 2015

Most Current Prior Effective Date: March 31, 2014

(A) This rule describes the conditions under which an individual may receive time-limited medical assistance as a result of an initial, simplified determination of eligibility based on the individual's self-declared statements.

(B) Eligibility criteria for presumptive coverage.

(1) Limitations. An individual is ineligible for a subsequent presumptive coverage period for twelve months beginning on the date of a presumptive coverage determination, except that a woman may receive presumptive coverage based on pregnancy once during each pregnancy.

(2) Except as set forth in paragraph (B)(1) of this rule, an individual is eligible for presumptive coverage if the individual:

(a) Is a resident of the state of Ohio; and

(b) Is a U.S. citizen or has an immigration status as defined in rule 5160:1-1-58.3 of the Administrative Code that allows for medicaid eligibility; and

(c) Meets the non-financial eligibility criteria for a group set out in rule 5160:1-1-63, 5160:1-1-63.1, 5160:1-1-64, or 5160:1-1-65 of the Administrative Code, except that a simplified determination of household composition will be done, whereby household composition comprises the individual and, if living in the home:

(i) The individual's spouse;

(ii) The individual's children under age 19; and

(iii) If the individual is under age 19:

(a) The individual's parents; and

(b) The individual's siblings under the age of 19.

(d) Has gross family income, for the individual's family size, of no more than the eligibility limit set out for the relevant eligibility group in rule 5160:1-1-63, 5160:1-1-63.1, 5160:1-1-64, or 5160:1-1-65 of the Administrative Code.

(C) Duration and scope of presumptive coverage.

(1) Presumptive coverage begins on the date an individual is determined to be presumptively eligible. No retroactive coverage may be provided as a result of a presumptive eligibility determination.

(2) Presumptive coverage ends on the earlier of (and includes):

(a) The date the administrative agency determines that the individual is eligible or ineligible for ongoing medical assistance pursuant to rule 5160:1-1-51 of the Administrative Code; or

(b) If an application for ongoing medical assistance for the individual has not been filed, the last day of the month following the month in which the individual was determined to be presumptively eligible.

(3) Presumptive eligibility services for individuals found presumptively eligible on the basis of pregnancy are restricted to ambulatory prenatal care.

(D) State agency responsibilities. The Ohio department of medicaid (ODM) must:

(1) Provide qualified entities (QEs), as defined in rule 5160:1-1-50.1 of the Administrative Code, with:
Such forms as are necessary for applications to be submitted for medical assistance under the state plan; and

Information on how to assist individuals in completing and filing such forms.

(2) Monitor the performance of each qualified entity (QE), as specified in the presumptive coverage addendum to their operating agreement, on the basis of the percent of completed applications for ongoing medical assistance, to determine that the QE has provided appropriate assistance to presumptively eligible individuals.

(3) Determine if a QE is in compliance with the presumptive coverage addendum to their operating agreement and notify any QE found not to be in compliance that the QE is no longer authorized to determine presumptive eligibility.

(E) Qualified entity (QE) responsibilities.

(1) If the QE is a CDJFS:

(a) No later than the end of the business day after receipt of a signed and dated application for medical assistance on behalf of an individual, the CDJFS must determine, based on the individual's self-declared information, whether an individual is eligible for presumptive coverage under this rule.

(b) If an individual is eligible for presumptive coverage, the CDJFS must:

(i) Approve presumptive coverage for the individual; and

(ii) Inform the individual of:

(a) The presumptive coverage, and

(b) That failure to cooperate with the eligibility determination process set forth in rule 5160:1-1-51 of the Administrative Code will result in a denial of medical assistance, which will trigger the termination of presumptive coverage.

(iii) Not make an absent parent referral described in rule 5101:1-3-10 of the Administrative Code as a part of the approval of presumptive eligibility coverage.

(c) If an individual is not eligible for presumptive coverage, the CDJFS must inform the individual that the individual's eligibility for medical assistance will be determined.

(d) Whether or not an individual is eligible for presumptive coverage, the CDJFS must determine whether the individual is eligible for ongoing medical assistance pursuant to rule 5160:1-1-51 of the Administrative Code.

(2) If the QE is a hospital, the department of youth services (DYS), a federally-qualified health center (FQHC), as defined in rule 5160-28-01 of the Administrative Code, or a FQHC look-alike:

(a) Upon request, or if the QE believes the individual may meet the criteria for presumptive eligibility, determine whether the individual is presumptively eligible under this rule. Such determination shall not be delegated to a third party, but shall be done by the QE.

(b) Accept self-declaration of the presumptive eligibility criteria unless contradictory information is provided to or maintained by the QE.

(c) If the individual is presumptively eligible:

(i) Approve presumptive coverage for the individual using the electronic eligibility system designated by ODM in the presumptive eligibility operating addendum to the QE's provider agreement; and

(ii) Provide the individual, at the time of determination, with a notice of the individual's presumptive eligibility. Such notice must include the individual's:

(a) Presumptive eligibility determination date;
(b) Basis for presumptive eligibility;
(c) Name, date of birth, and address;
(d) Medicaid information technology system (MITS) billing number; and
(e) A reminder that the individual must apply for ongoing medical assistance no later than the last day of the following month.

(iii) Take all reasonable steps to help the consumer complete the application for ongoing medical assistance or make contact with the CDJFS.

(d) If the individual is not presumptively eligible, inform the individual that there may be other categories of medical assistance available to the individual, and that the individual should apply for a full determination of eligibility for medical assistance.

(e) Disqualification of QEs. A QE may be disqualified if ODM finds that a QE is not:
   (i) Making, or is not capable of making, presumptive eligibility determinations, or
   (ii) Complying with the QE responsibilities as described in this rule and in any agreement required by ODM.

(F) Denial of presumptive coverage is not grounds for a state hearing under division 5101:6 of the Administrative Code.

Effective:
Five Year Review (FYR) Dates: 03/31/2019
Certification
Date
Promulgated Under: 111.15
Statutory Authority: 5163.02
Rule Amplifies: 5163.01, 5163.02, 5163.10, 5163.101
Prior Effective Dates: 4/1/91 (Emer.), 6/1/91, 9/1/92, 9/1/93, 7/1/00, 4/1/10 (Emer.), 7/1/10, 4/1/12 (Emer.), 4/1/12, 7/1/12, 3/31/14
Medicaid: Continuous Eligibility for Children Younger Than Age Nineteen

This rule describes the twelve-month period of continuous eligibility for a child younger than age nineteen, and the conditions under which the child's coverage ends during the twelve-month period, as described in section 1902(e)(12) of the Social Security Act (as in effect on October 1, 2013).

Eligibility criteria. A child remains eligible for coverage despite changes in the child's circumstances for a period of twelve months if the child was found to be eligible for a category of medical assistance other than:

1. Presumptive eligibility as described in Chapter 5160:1-1 or Chapter 5160:1-2 of the Administrative Code;

2. Alien emergency medical assistance as described in rule 5160:1-5-20 or 5160:1-1-91 of the Administrative Code; or

3. Refugee medical assistance as described in rule 5160:1-6-90 of the Administrative Code.

Duration.

1. A child's twelve-month period of continuous eligibility begins:
   
   a. On the date that medical assistance began as a result of an initial determination or annual redetermination in accordance with rule 5160:1-2-01.2 or rule 5160:1-1-51 of the Administrative Code.
   
   b. Without regard to any months of retroactive eligibility.

2. The child's coverage shall be terminated during the continuous eligibility period only:
   
   a. Upon oral or written request of the child (if the child is at least eighteen years old) or the child's representative; or
   
   b. When the child:
      
      i. No longer resides in the state of Ohio; or
      
      ii. Dies; or
      
      iii. Has not paid the premium amounts required for coverage, if the child is covered under the medicaid buy-in for workers with disabilities category described in rule 5160:1-5-30 of the Administrative Code; or
      
      iv. Reaches age nineteen.

Spenddown, patient liability, or premium.

1. A spenddown, patient liability, or premium calculated for a child in accordance with Chapters 5160:1-3 to 5160:1-6 of the Administrative Code shall not increase during the child's continuous coverage period. Any decrease in a child's spenddown, patient liability, or premium results in a new maximum amount, which will not increase for the remainder of the child's continuous coverage period.

2. If a child is eligible for medical assistance only through the spenddown process set forth in Chapter 5160:1-3 of the Administrative Code, the child will not receive medical assistance in any month until the child's spenddown has been satisfied for that month.

Regardless of a child's status under this rule, payment for services shall not be made if payment is prohibited under rule 5160:1-1-58.1 of the Administrative Code.

Replaces: 5160:1-2-30
Effective: 01/01/2014
R.C. 119.032 review dates: 01/01/2019
Certification: CERTIFIED ELECTRONICALLY
Date: 12/20/2013
Promulgated Under: 111.15
Statutory Authority: 5162.031, 5163.02
Rule Amplifies: 5163.02, 5163.03
Prior Effective Dates: 4/1/10 (Emer, ), 7/1/10, 10/15/10
MEMMTL 2

Effective Date: October 1, 2013

(A) This rule describes eligibility for pregnant women as described in 42 C.F.R. 435.116 (as in effect on April 1, 2013) for applications for medical assistance filed on or after January 1, 2014.

(B) Eligibility criteria for coverage because a woman is pregnant.

(1) The individual must be female and pregnant. Unless the administrative agency has information contradicting an individual's statement, the individual's statement is sufficient verification of her pregnancy.

(2) The woman's household income must not exceed two hundred per cent of the federal poverty level for the family size.

(C) Eligibility span for pregnant women.

(1) Once established, eligibility for a pregnant woman continues throughout her pregnancy and postpartum period.

(2) A woman is eligible for postpartum coverage if she was eligible for medicaid on the date her pregnancy ends. This includes a birth mother whose labor and delivery services were furnished prior to the date of application and who is determined eligible for retroactive coverage of the labor and delivery services as described in rule 5101:1-37-51 of the Administrative Code.

(D) Administrative agency responsibilities. The administrative agency must:

(1) Calculate a pregnant woman's family size and household income as described in rule 5101:1-37-61 of the Administrative Code.

(2) Inform a pregnant woman who has indicated that she is carrying more than one fetus whether medical verification of her pregnancy might, by increasing her family size, cause her to be income-eligible for medicaid.

(3) Not terminate eligibility for a pregnant woman during her pregnancy or postpartum period unless the woman dies, moves out of state, or requests that coverage be terminated.

(E) Individual responsibilities. The individual must provide medical verification of pregnancy, only if necessary for income eligibility by increasing the family size.

Effective:
R.C. 119.032 review dates:
Certification
Date
Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011
Rule Amplifies: 5111.01, 5111.011, 5111.013, 5111.014
MEMMTL 2

Effective Date: October 1, 2013

(A) This rule describes eligibility for parents and caretaker relatives residing with children as described in 42 C.F.R. 435.110 (as in effect on April 1, 2013) for applications for medical assistance filed on or after January 1, 2014.

(B) Eligibility criteria for coverage because an individual is a parent or caretaker relative residing with a child.

(1) The individual must be residing with a dependent child under the age of eighteen. An individual is considered to be residing with the child even if the child is temporarily absent with the intent to return home.

(2) The individual must be the child's parent or caretaker relative, or a spouse residing with the child's parent or caretaker relative.

(3) An individual must not be subject to an OWF sanction, unless the individual has agreed to comply with the work activity. The sanctioned individual shall regain medicaid eligibility beginning on the first day of the month in which the individual agrees to comply with the work activity.

(4) The individual's household income must not exceed ninety per cent of the federal poverty level for the family size.

(C) Transitional medical assistance (TMA) or extended medical assistance (EMA).

(1) To be eligible for TMA or EMA an individual must have:

(a) Been eligible for and enrolled in medicaid:

(i) For at least three of the six months immediately preceding the loss of eligibility.

(ii) As a parent or caretaker relative, or as the minor child of a parent or caretaker relative, eligible under paragraph (B) of this rule.

(b) Become ineligible for medicaid under this rule as a result of an increase in:

(i) Earned income, to be eligible for TMA. Verification of increased income is not required and can be self-declared.

(ii) Increased collection of spousal support, to be eligible for EMA. Verification of increased income is not required and can be self-declared.

(2) Duration of eligibility.

(a) A parent or caretaker relative is eligible for:

(i) Four months of EMA beginning the month immediately following the last month the individual had income below the threshold for coverage as a parent or caretaker relative. Any months of medicaid received in error due to unreported income are counted as months of EMA.

(ii) Twelve months of TMA beginning the month immediately following the last month the individual had income below the threshold for coverage as a parent or caretaker relative. Any months of medicaid received in error due to unreported income are counted as months of TMA.

(b) A child remains eligible under rule 5101:1-37-63 for a continuous period of twelve months. At the end of that twelve-month period, the child becomes eligible for any remaining months of TMA or EMA for which the parent or caretaker relative is eligible, ending in the same month as TMA or EMA ends for the parent or caretaker relative.
(3) Resuming interrupted spans of eligibility. If an individual whose span of TMA was interrupted because the individual became eligible for coverage under paragraph (B) of this rule subsequently loses eligibility under paragraph (B) due to an increase in earned income, the individual is eligible for any remaining months or the original TMA span.

(4) Repeated spans of eligibility. There is no limit to the number of times an individual may receive coverage under TMA or EMA, provided that the individual meets all of the relevant criteria for the coverage each time.

(D) Administrative agency responsibilities. The administrative agency must:

(1) Calculate a parent's or caretaker relative's family size and household income as described in rule 5101:1-37-61 of the Administrative Code.

(2) Consider an individual's eligibility for TMA or EMA as part of the redetermination and pre-termination review processes described in rule 5101:1-37-51 of the Administrative Code.

   (a) Verify in the electronic eligibility system the individual was receiving medicaid in previous months. Approve TMA or EMA if an individual meets the requirements in paragraph (C) of this rule;

   (b) Deny or terminate TMA or EMA when:

      (i) There is no longer a child residing with the parent or caretaker relative, or

      (ii) All individuals become eligible for another medicaid covered group.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 111.15

Statutory Authority: 5111.01, 5111.011

Rule Amplies: 5111.01, 5111.011
MEMMTL 4

(A) This rule describes eligibility criteria for coverage of treatment of an emergency medical condition for certain individuals who do not meet the medicaid citizenship or satisfactory immigration status requirements described in rule 5160:1-1-58.2 or 5160:1-1-58.3 of the Administrative Code.

(B) Definition. "Emergency medical condition", for the purposes of this rule, means a medical condition with a sudden onset:

1. Manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
   - (a) Placing the patient's health in serious jeopardy;
   - (b) Serious impairment to bodily functions; or
   - (c) Serious dysfunction of any bodily organ or part;

2. Including labor and delivery, but

3. Not including either:
   - (a) Routine prenatal or postpartum care, or
   - (b) Care and services related to an organ transplant procedure.

(C) Eligibility criteria. The individual must:

1. Have received treatment for an emergency medical condition.
2. Submit an application for medical assistance for the dates of a particular emergency medical episode.
3. Meet eligibility criteria for a category of medicaid, except that the individual:
   - (a) Does not meet the medicaid citizenship or non-citizen requirements set forth in rules 5160:1-1-58.2 and 5160:1-1-58.3 of the Administrative Code. The individual is not required to verify the individual's:
     - (i) Social security number, or
     - (ii) Citizenship or immigration status.
   - (b) Is not required to apply for social security administration (SSA) benefits. If the individual is otherwise eligible for a category of medicaid that requires a disability determination, the administrative agency shall submit a disability determination packet to the disability determination area (DDA) in accordance with rule 5101:1-39-03 of the Administrative Code.

(D) Eligibility span. Coverage for an individual who meets the criteria in paragraph (C) of this rule:

1. Begins on the day on which the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, and
2. Ends on the day on which the absence of immediate medical attention could no longer reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The emergency medical condition episode:
   - (a) Includes labor and delivery, but
   - (b) Does not include ongoing treatment.

(E) Administrative agency responsibilities. The administrative agency shall:
(1) Determine the eligibility span for routine labor and delivery without submitting medical documentation to the DDA for a determination, and enter it into the electronic eligibility system in accordance with the following policy:

(a) The eligibility span begins on the date of admission for labor, and ends at midnight of the day in which one of the following time periods falls:

   (i) A maximum of two days (forty-eight hours) following a vaginal delivery; and

   (ii) A maximum of four days (ninety-six hours) following a caesarian section delivery.

(b) The time period beginning on the date of admission for labor and ending on the date of delivery shall not exceed two days (forty-eight hours).

(2) Submit medical documentation to the DDA for a determination of the covered dates of service when:

(a) The time period beginning on the date of admission for labor and ending on the date of delivery is greater than two days (forty-eight hours); or

(b) The labor and delivery episode from admission through discharge exceeds the timeframes described in paragraph (E)(1)(a) of this rule.

(3) For emergency medical conditions other than routine labor and delivery as described in paragraph (E)(1) of this rule, enter the eligibility span determined by the DDA into the electronic eligibility system.

(4) Upon request, assist the individual in obtaining medical documentation to support the AEMA claim.

(F) Disability determination area (DDA) responsibilities. The DDA shall:

(1) Make all emergency medical condition determinations except for routine labor and delivery cases, as described in paragraph (E)(1) of this rule.

(2) Determine if the individual received treatment for an emergency medical condition.

(3) Determine the eligibility span for the emergency medical condition episode.

(4) Notify the administrative agency of the AEMA determination and the eligibility span via the electronic eligibility system.

Effective: 01/01/2014
R.C. 119.032 review dates: 01/01/2019
Certification: CERTIFIED ELECTRONICALLY
Date: 12/20/2013
Promulgated Under: 111.15
Statutory Authority: 5162.031, 5163.02
Rule Amplifies: 5163.02
ODM 01137-SPA Suplemento al Cuidado de Ninos/Comienzo Saludable y Familias Saludables
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=01137
ODM 02399  Request for Medicaid Home and Community-Based Services (HCBS)

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=02399
ODHS 2601 Investigation At Death

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=02601
Authorization for the Release or Use of Protected Health Information (PHI)

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03397
Instructions for Completing the Pregnancy Related Services Implementation Plan

http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM03515-I.docx
ODM 03528    Healthchek and Pregnancy Services Assessment
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03528
Evaluacion de los Servicios Healthchek y de Embarazo

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03531
Healthchek and Pregnancy Related Services Information

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03538
County Medical Services Disability Determination

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03600
ODM 03605    ODM Referral to CMS
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03605
ODM 03606  Disability Medical Assistance (DMA) Physician Certification of Medication Dependency

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03606
ODM 03748    Certificate of Group Plan Health Coverage
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03748
ODM 03749-SPA Autorizacion Del Certificado De Cobertura Del Plan Medico Grupal

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03749
ODHS 3900 Notice of Intercounty Transfer
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03900
ODM 04077  Resource Transfer Worksheet

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=04077
ODM 04077-SPA Hoja de Computacion para la Transferencia de Recursos
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=04077
ODM 04078-SPA Hoja de Computacion del Ingreso Mensual Permitido (MIA por sus siglas en ingles)

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=04078
ODM 04206-SPA Hoja de Computacion del Monto Familiar Permitido (FA por sus siglas en ingles) y el Monto Permitido para Necesidades de Mantenimiento Familiar (FMNA por sus siglas en ingles)

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=04206
ODM 04207  Restricted Medicaid Coverage Period Determination

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=04207
ODM 06612 Health Insurance Information Sheet
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=06612
ODM 06613       Accident/Injury Insurance Information Form

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=06613
Designation of Authorized Representative

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=06723
ODM 07078  ODM Code of Responsibility

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07078
ODM 07095     Overpayment Determination Form

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07095
Changes in Medical Assistance Health Care Coverage Dates/Buy-In Eligibility

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07102
ODM 07103-SPA Solicitud Para Recibir Ayuda Con Los Gastos De Medicare
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07103
ODM 07104    Application/Reapplication Verification Request

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07104
ODM 07105  Application/Reapplication Verification Request Checklist

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07105
ODM 07106       Notice of Requirement to Transfer Excess Resources

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07106
ODM 07107  Notice of Interim Assistance Reimbursement

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07107
Notification of New Citizenship Requirement for Medicaid
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07111
ODM 07111-SPA Notificacion del Nuevo Requisito de Ciudadania de Medicaid

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07111
Important Notice - Medicare Supplemental Insurance Policies (MEDIGAP)

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07114
ODM 07115    Transitional Medicaid

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07115
ODM 07138  Medicaid Approval Notice With a Restricted Medicaid Coverage Period

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07138
ODM 07138-SPA Aviso de Aprobacion de Medicaid Con un Periodo de Cobertura de Medicaid Restringido

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07138
Notificacion de Aprobacion de su Solicitud para Medicaid: En Casos de Conyuges con Sociedad Conyugal

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07139
Availability of Hardship Exemption

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07140
Decision on Your Request for a Hardship Exemption

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07141
ODM 07141-SPA Decision acerca de su Solicitud de Exencion por Adversidad

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07141
ODM 07161-SPA Proyecto de Cancer Cervical y de Seno del Estado de Ohio ("BCCP") Solicitud de Medicaid

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07161
ODM 07202     Part A Buy-In for Qualified Working Disabled Individuals

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07202
Explicacion de "Beneficiario Calificado de Medicare" ("QMB"), por sus siglas en ingles) Cobertura de Medicaid

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07212
ODM 07213 Notice of Failure to Submit Resource Documentation for the Resource Assessment

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07213
ODM 07214       Resource Transfer Statement

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07214
ODM 07216 Application for Health Coverage and Help Paying Costs
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07216
ODM 07220       Medicaid Eligibility Review Verification Request Checklist

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07220
ODM 07220-SPA Lista de Verificacion de Healthy Stara/Healthy Families
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07220
Authorization for Reimbursement of Interim Assistance Initial Posteligibility Payment.

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07233
ODM 07236-SPA Sus Derechos Y Responsabilidades Como Sonsumidor De Servicios Medicos De Medicaid

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07236
ODM 07237  Healthy Start/Healthy Families (Comienzo Saludable y Familias Sanas)
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07237
ODM 07302    Basic Medical

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07302
ODM 07332      Notice of Denial of Your Application for Medicaid: In Cases Involving Community Spouses

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07332
ODM 07332-SPA Notificacion de Denegacion de su Solicitud para Medicaid: En Casos que Involucren a Conyuges con Sociedad Conyugal

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07332
ODM 07350  |  Spend-Down Eligibility
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07350
ODM 07355 Notice of Application for Social Security Number
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07355
ODM 07400       Ohio Medicaid Estate Recovery

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07400
ODM 07400-SPA Recuperacion Del Patarimonio Hereditario Por Parte Medicaid Del Estado De Ohio

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07400
Community Spouse Resource and Income Information

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07403
ODM 07405  Third Party Affidavit of Birthplace or Nationality
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07405
ODM 07405-SPA Declaración Jurada de Terceros sobre Lugar de Nacimiento o Nacionalidad
http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07405
ODM 07407-SPA Declaración Jurada del Padre/Guardian Legal sobre la Identidad de un Nino Menor de 16 Anos

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=07407
Healthy Start for a Healthy Baby

http://www.odjfs.state.oh.us/forms/findform.asp?formnum=08062
Other Agency Forms
SSA-1696   Appointment of Representative

[Click here to view the SSA-1696]
Transitional ADC- Related Medicaid Quarterly Report Form

Click here to view the Transitional ADC- Related Medicaid Quarterly Report
U.S. Department of Veterans Affairs Facility Contact Person for VA Facilities Located in Ohio.

Click here to view the listing of U.S. Department of Veterans Affairs Facility Contact Person for VA Facilities Located in Ohio
U.S. Department of Veterans Affairs Facility Contact Person for VA Facilities Located Outside Ohio.

Click here to view the listing of U.S. Department of Veterans Affairs Facility Contact Person for VA Facilities Located Outside Ohio
Voter Registration Form
Click here to view the Voter Registration Form.
Voter Registration Transmission Form

Click here to view the Voter Registration Transmission Form.
National Mail Voter Registration Application
(for U.S. citizens only)
Click here to view an example of the, "For U.S. Citizens Only" Form.
A Designated Voter Registration Agency Notice of Rights

Click here to view the example of A Designated Voter Registration Agency Notice of Rights.
Sample Forms
Healthchek/PRS LPMD Instructions

Click here to view the Healthchek/PRS LPMD Instructions
Healthchek/PRS Sample LPMD Templates

Click here to view the Healthchek/PRS Sample LPMD Templates
(Sample) Notification of SSA Appeal Requirement for Continued Medicaid

Click here to view the Sample Notification of SSA Appeal Requirement for Continued Medicaid
Certification Letter (Adult)

Click here to view the sample of the Adult Certification letter
Letter for Children

Click here to view the sample of the Letter for Children
Authorization for County Welfare Department to Endorse Warrant - Power of Attorney

Click here to view the suggested format for Authorization For County Welfare Department To Endorse Warrant - Power of Attorney
Suggested Format for Informed Release

Click here to view an example of the Suggested Format for Informed Release
Sample Format to a Potential Applicant

Click here to view an example of the Sample Format to A Potential Applicant
Document Receipt

Click here to view the example of the Document Receipt
Click here to view an example of the Application Information Letter
Application Follow-Up Letter

Click here to view the example of the Application Follow-up Letter
MEM Desk Aids
BIC Report
CFC/MPAP FPL BIC Report Instructions

Click here to view the CFC/MPAP FPL BIC Report Instructions
Click here to view the MBIWD FPL BIC Instructions
2009 Social Security Cost of Living Adjustment (COLA)

Click here to view the 2009 Social Security Cost of Living Adjustment (COLA)
2009 Social Security Cost of Living Adjustment (COLA)

Click here to view the 2009 Social Security Cost of Living Adjustment (COLA)
ODJFS HIPAA Privacy Notice

Click here to view the ODJFS HIPAA Privacy Notice
Income Standards
Medicaid Eligibility Trainings
Click here to view the Medicaid Eligibility Policy Video Conference - August, 2005 presentation
Click here to view the Medicaid Eligibility Policy Video Conference - July 2005 Presentation
Click here to view the Medicaid Eligibility Policy Video Conference - June 13, 2005 presentation
Medicaid Eligibility Policy Video Conference - December 2004

Click here to view the Medicaid Eligibility Policy Video Conference - December 2004 presentation
Click here to view the Medicaid Eligibility Policy Video Conference - November 2004 presentation
Click here to view the Medicare Approved Drug Discount Card - Summer (2004) presentation

This is a very large file and may take a moment to open.

Click here to view the Alien Emergency Medical Assistance (AEMA) Eligibility - Spring (2004) presentation
This is a very large file and may take a moment to open.

Click here to view the ABD Eligibility Training - Winter (2002) presentation
CFC Eligibility Trainings - Spring (2002)

This is a very large file and may take a moment to open.

Click here to view the CFC Eligibility Trainings - Spring (2002) presentation (rules contained in PAMTL 430)
This is a very large file and may take a moment to open.

Click here to view the Breast and Cervical Cancer Program (BCCP) Eligibility Training - Spring (2002) presentation
This is a very large file and may take a moment to open.

Click here to view the Spenddown Eligibility Training - Winter (2002) presentation
This is a very large file and may take a moment to open.

Click here to view the PAMTL 433 Eligibility Training - Spring (2002) presentation
ODJFS Training Manuals
Click here to view the ODJFS training manuals
http://odjfstcdu.ev.net/manuals/index.htm
Please note that the ODJFS training manuals may not reflect the most current policy or OAC rule changes.
View Flash Bulletins
Click here to view #162 - CLVB, MEMTL 99
#156 - CLVB, MEPL 96 - Medicaid: Ninety Day Reinstatement
Click here to view #156 - CLVB, MEPL 96 - Medicaid: Ninety Day Reinstatement
#137 - CLVB, MBIWD: MEPL 88 - 2014 FPL increase

Click here to view #137 - CLVB, MBIWD: MEPL 88 - 2014 FPL increase
#132 - CLVB, Medicaid: Coverage for Certain Individuals

Click here to view #132 - CLVB, Medicaid: Coverage for Certain Individuals
#123 - CLVB, Medicaid: MEPL 79, 2013 MMMNA and ESA Standards Deeming Calc Update

Click here to view #123 - CLVB, Medicaid: MEPL 79, 2013 MMMNA and ESA Standards Deeming Calc Update
#122 - CLVB, Medicaid: MEPL 78, Deeming Calc Update

Click here to view #122 - CLVB, Medicaid: MEPL 78, Deeming Calc Update
Click here to view #121 - CLVB, MBIWD: MEPL 77 - 2013 FPL Increase
#113 - CLVB, Medicaid: MEPL 70 Medicaid: Standard Utility Allowance Decrease

Click here to view #113 - CLVB, Medicaid: Standard Utility Allowance Decrease
#112 - CLVB, Medicaid: MEPL 67 No Changed to SUA

Click here to view #112 - CLVB, Medicaid: MEPL 67 No Changed to SUA
#111 - CLVB, Medicaid: Presumptive Eligibility for Children Younger Than Age Nineteen

Click here to view #111 - CLVB, Medicaid: Presumptive Eligibility for Children Younger Than Age Nineteen
Click here to view #110 - CLVB, ABD Deeming Calculator Update
Click here to view #109 - CLVB, Medicaid: 2012 Federal Poverty Level Income Guidelines for MBIWD
#97 - CLVB, MEPL 58 - Medicaid: Deeming Calculator

Click here to view #97 - CLVB, MEPL 58, Medicaid: Deeming Calculator
Click here to view #91 - CLVB, Medicaid: MEPL 53 - 2011 FPL
#89 - CLVB, Medicaid: Update to Table TWDT

Click here to view #89 - CLVB, Medicaid: Update to Table TWDT
Medicaid: Special Immigrant Visa Changes

Click here to view #85 - CLVB, MEMTL 67 - Medicaid: Special Immigrant Visa Changes
Click here to view #84 - CLVB, MEPL 49 - Medicaid: Part D $250.00 Rebate
#79 - CLVB, MEPL 45 - Medicaid: Reasonable Opportunity to Provide Documentary Proof of Citizenship

Click here to view #79 - CLVB, MEPL 45 - Medicaid: Reasonable Opportunity to Provide Documentary Proof of Citizenship
Click here to view #78 - CLVB, MEMTL 64 - Medicaid: Rescission of Rule 5101:1-39-53.5 Direct Reimbursement for QMB or SLMB Medicaid
Click here to view #68 - CLVB - MEMTL 55, Medicaid: Safeguarding, IVES and Certificate of Creditable Coverage and Privacy Notice
Click here to view #60 - CLVB, MEPL 35A - Medicaid: Special Instructions for Treatment of Unemployment Compensation/FAC in MBIWD Premium Calculations
Click here to view #58 - CLVB, MEPL 36 - Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities
#56 - CLVB, MEPL 34 - Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Click here to view #56 - CLVB, MEPL 34 - Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards
Click here to view #52 - CLVB, MEPL 31 - Medicaid: 2009 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and Transitional Medical Assistance
#50 - CLVB, MEPL 30 - 2009 Social Security Cost of Living Adjustment (COLA)

Click here to view #50 - CLVB, MEPL 30 - 2009 Social Security Cost of Living Adjustment (COLA)
#48 - CLVB, MEPL 28 - Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Click here to view #48 - CLVB, MEPL 28 - Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards
#43 - Medicaid: MEPL 15 - 2007 FPL

Click here to view Medicaid: MEPL 15 - 2007 FPL
#42 - Medicaid Eligibility Reduction

[Click here to view Medicaid Eligibility Reduction]
Click here to view the Report BON003-R002 Available
#40 - MEPL 8 Student Child EI Exclusion

Click here to view the MEPL 8 Student Child EI Exclusion
Click here to view the MEPL 7 Consumer Price Index (CPI) and Social Security cost of living adjustment (COLA)
#37 - MEPL 3 Increase in the NF average private pay rate

[Click here to view the MEPL 3 Increase in the NF average private pay rate](#)
#36 - MEPL 2 MMMNA and Excess Shelter Allowance

Click here to view the MEPL 2 MMMNA and Excess Shelter Allowance
#35 - MEPL 1 Household of Another Need Standards

Click here to view the MEPL 1 Household of Another Need Standards
Click here to view the MEMTL 19 JFS 07124.
Click here to view the 2005 Federal Poverty Levels.
#32 - Spousal Impoverishment Standards Increase for 2005

Click here to view the Spousal Impoverishment Standards Increase for 2005.
#31 - COLA Mass Change for January 2005

Click here to view the COLA Mass Change for January 2005.
Click here to view the Qualified Individuals-1 (QI-1).
Click here to view the MIL 04-016 Disability Medical Assistance Administrative Order.
Click here to view the AEMA Labor and Delivery Cases.
Click here to view the Medicaid Eligibility Video Conference.
Click here to view the Medicaid Eligibility Video Conference.
Click here to view the Medicaid: CRIS-E Table TMEP Update - Increase in Standard Utility Allowance.
Click here to view the MIL 04-015 Disability Medical Assistance Administrative Order.
Click here to view the MIL 04-014 Medicare-Approved Drug Card.
#22 - Medicare Discount Card

Click here to view the Medicare Discount Card.
Click here to view the MIL 04-013 DMA.
Click here to view the ACT 234 SAVE.
#19 - ACT 233 MMMNA and ESA

Click here to view the ACT 233 MMMNA and ESA.
#18 - MEMTL 11 Translated Forms and Revised CPA

Click here to view the MEMTL 11 Translated Forms and Revised CPA.
#17 - ACT 232 Income Standard Changes

Click here to view the ACT 232 Income Standard Changes.
Click here to view the ACT 231 FPL Income Standards.
#15 - Pre-termination review for BCCP

[Click here to view the Pre-termination review for BCCP.](#)
Click here to view the ACT 230 Student Child Earned Income.
#12 - MIL 03-009A DMA Amendment

Click here to view the MIL 03-009A DMA Amendment.
Click here to view the MEMTL 9 AEMA.
Click here to view the ACT 228 QI-1.
Click here to view the ACT 227 QI-1 Shut Down.
#8 - QI-1 Shut Down

Click here to view the QI-1 Shut Down.
#7 - ACT 226 Standard Utility Allowance

Click here to view the ACT 226 Standard Utility Allowance.
Click here to view the Pre-termination review for DMA.
#4 - NF Increase in Pay Rate

Click here to view the NF Increase in Pay Rate.
#3 - HIPAA forms

Click here to view the HIPAA forms.
#2 - JFS 01137 Child Care Application

Click here to view the JFS 01137 Child Care Application.
Contact Us

Welcome to the electronic Medicaid Eligibility Manual (MEM). The purpose of the MEM is to provide a user-friendly electronic manual for all Medicaid customers in the public and private sector. The Medicaid Eligibility Policy Unit is responsible for the design and maintenance of the electronic MEM.

Please note: Technical assistance is not provided through this site. Any technical assistance questions should be directed to MEDICAID_ELIGIBILITY_TA@odjfs.state.oh.us.

Helpful Links and Phone Numbers


Case-Specific Concerns: [https://www.odjfs.state.oh.us/oleg-form/CaseSpecific.asp](https://www.odjfs.state.oh.us/oleg-form/CaseSpecific.asp) or [http://jfs.ohio.gov/feedback/](http://jfs.ohio.gov/feedback/)

Medicaid Consumer Hotline: 1-800-324-8680 or (TTY) 1-800-292-3572

Weekly e-Mail Notification

To receive e-Mail Notification weekly of all ODJFS policy updates, subscribe to the Handbook Updates Subscription e-mail by sending an e-mail to:

HANDBOOK_UPDATE_SUBSCRIPTIONS@odjfs.state.oh.us.

Enter the word "subscribe" in lowercase letters in the subject line.

The email notification is sent every Friday afternoon which includes all new policy letters.
Archived MILs

The following Medicaid Information Letters (MILs) are being provided for user convenience.
The Ohio Department of Aging has updated the average private pay rate for nursing facilities. Effective July 1, 2003, the average monthly private pay rate will be increased from $3,903 to $4,512. CRIS-E reference table TMEP has been updated to reflect this increase for recurring budgets for June 1, 2003.

A new period of restricted coverage is not computed for individuals currently in a penalty period. The CDJFS is not required to recompute an improper transfer penalty period unless there is new information regarding the improper transfer (e.g., the resource was returned to the individual). The original notice that was issued to the applicant/recipient is still valid.

If you have any questions, please contact the ABDTA mailbox through Groupwise.

This information is also available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/oheligibility/MEM
MIL 03-009A (DMA Amendment)

Medicaid Information Letter: 03-009A

January 6, 2004

To: Directors, County Departments of Job and Family Services
Attention: Income Maintenance Administrators and Supervisors

From: Thomas J. Hayes, Director

Subject: Amendment to Medicaid Information Letter No. 03-009

Disability Medical Assistance Administrative Order

Redeterminations OAC 5101:1-42-01

The Disability Medical Assistance (DMA) program remains under an administrative freeze as defined in MIL 03-009. Effective January 1, 2004, an administrative decision was made to modify the redetermination process for DMA. This modification is a result of the number of DMA consumers who have lost eligibility due solely to a failure to complete a scheduled redetermination.

Individuals whose DMA cases were terminated effective December 31, 2003 or later due to failure to keep a redetermination appointment will be allowed a one month grace period after the termination of DMA in which to reapply for DMA without being subject to the administrative freeze. Individuals who apply during the grace period and are determined eligible for DMA are eligible for DMA retroactive to the first of the month of the grace period.

If the individual contacts the county department of job and family services (CDJFS) during the grace period the CDJFS must provide an opportunity for the individual to file an application within the grace period. The grace period process described in this letter is only applicable to DMA and does not apply to any other category of assistance. The rules containing applicable policy with regard to food stamps and all cash assistance programs are to be followed. Those rules are 5101:4-2-01 and 5101:4-7-07 (food stamps) and 5101:1-2-01 and 5101:1-2-10 (OWF/DFA).

The CDJFS must file DMA using reason code 050 to authorize DMA retroactive to the first of the month of the grace period.

This change is in effect until further notice. Please ensure that all appropriate staff are notified of the information in this MIL.

Example:
An individual fails to keep his redetermination appointment on December 3rd. A PTR is completed and prior notice is issued. DMA benefits are terminated effective December 31, 2003. If he reapplys for DMA prior to February 1, 2004, his application should be processed without regard to the administrative freeze. If eligible, the beginning date of eligibility is January 1, 2004. If he applies for DMA February 1, 2004 or later he will be subject to the administrative freeze and the application must be denied using reason code 693.

Example:
An individual fails to keep his redetermination appointment on December 20, 2003. A PTR is completed and prior notice is issued. DMA benefits are terminated effective January 31, 2004. If he reapplys for DMA prior to March 1, 2004 his application should be processed without regard to the administrative freeze. If eligible, the beginning date of eligibility is February 1, 2004. If he applies for DMA March 1, 2004 or later he will be subject to the administrative freeze and the application must be denied using reason code 693.

This information is also available on the Internet and may be accessed at:
The ODJFS Electronic Manuals (previously known as dynaweb) has moved.

Please update your Bookmarks/Favorites in your Internet browser:
http://emanuals.ohio.gov/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar

The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.
MIL 04-013 (DMA Administrative Order)

Medicaid Information Letter: 04-013

July 8, 2004

To: Directors, County Departments of Job and Family Services
From: Thomas J. Hayes, Director
Subject: Disability Medical Assistance (DMA) Administrative Order

In MIL 03-009, the Department ordered the suspension of county approval of any new applications for Disability Medical Assistance (DMA) in order to ensure that DMA expenditures do not exceed the state's appropriation. The purpose of this MIL is to issue an order rescinding the suspension, so that the county departments of job and family services (CDJFS) shall resume processing applications filed July 15, 2004, and thereafter until such time that the Department orders another suspension. Due to continuing budgetary concerns, another suspension to the DMA program may occur at any time.

Instructions for Implementation of this MIL:

ODJFS:
1. ODJFS will issue a DMA flyer that the CDJFS may post and send to other agencies to conduct outreach related to this MIL.

CDJFS:
1. Effective July 15, 2004, the CDJFS shall determine eligibility for individuals who submit DMA applications on or after July 15, 2004 and authorize DMA for individuals who meet the DMA eligibility requirements. DMA eligibility cannot begin prior to July 15, 2004.
2. Effective July 15, 2004, the CDJFS shall determine eligibility for individuals who have pending CRISE cases under DMA (MA G) or the disability category of Medicaid (MA D). The individual is not required to complete a new JFS 07200 application. The CDJFS shall authorize DMA for individuals who meet the DMA eligibility requirements, regardless of a DMA denial prior to July 15, 2004. The CDJFS must obtain a JFS 03606 and re-run the case. DMA eligibility cannot begin prior to July 15, 2004.
3. Effective July 15, 2004, the CDJFS shall submit a weekly report to the Bureau of Consumer and Program Support containing the number of DMA applications received, approved, denied and pending during the previous week. This information must be sent via E-mail or fax to Lena Wells at wellsl@odjfs.state.oh.us or (614) 728-9201 by the close of business each Monday beginning July 26, 2004.
4. The CDJFS shall take action to make consumers aware of the information contained in this MIL, including posting the DMA flyer that is attached to this MIL.
5. The CDJFS shall notify local groups that serve the DMA population (e.g., mental health, MRDD and substance abuse boards, medical clinics and hospitals, etc.) about the issuance of this MIL and provide them with DMA flyers so that they may conduct consumer outreach.

This MIL rescinds MIL No. 03-009.

Attachment: DMA flyer

A CRIS-E View Flash Bulletin will be issued with the information contained in this MIL. This information is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals
InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar

Attachment

Click here to view the Disability Medical Assistance Program (DMA) Flyer.
MIL 03-009 (DMA Administrative Order)

Medicaid Information Letter: 03-009
Rescinded per MIL 04-013

7/1/2003

To: Directors, County Departments of Job and Family Services

From: Thomas J. Hayes, Director

Subject: Disability Medical Assistance Administrative Order

The Director of the Ohio Department of Job and Family Services (ODJFS), pursuant to rule 5101:1-42-01 of the Ohio Administrative Code, issues this Administrative Order to suspend the approval of all applications for Disability Medical Assistance (DMA).

Under this administrative order, all county departments of job and family services (CDJFS) must upon receipt of this order:

1. Deny all new applications for DMA that are received on or after July 1, 2003, until such time as this order is revised or rescinded.

2. Determine eligibility for Disability Assistance-medical (DA-medical) applications that were received prior to July 1, 2003 and are still pending an eligibility determination as of July 1, 2003. The CDJFS must use the DA-medical rules that were in effect prior to July 1, 2003. At the first redetermination of the assistance group's eligibility, the CDJFS must use the DMA rules that are in effect as of July 1, 2003.

3. Determine DMA eligibility for individuals approved for DA-medical at their regularly scheduled redetermination. If the individual does not meet the eligibility requirement of medication dependent, continuing eligibility must be terminated in accordance with appropriate notice and state hearing procedures.

Instructions for Implementation of this Administrative Order

In accordance with ORC 5115.12, the following instructions are to be followed for the purpose of implementing this Administrative Order:

1. For all new applications for DMA received on or after July 1, 2003, eligibility must be denied using reason code 693.

2. For all DA-medical applications that were pending as of June 30, 2003, the rules in effect prior to July 1, 2003 must be used to determine eligibility.

3. DA-medical recipients who are no longer eligible for DMA as a result of a DMA eligibility determination made at the recipient's first redetermination must be issued a prior notice of termination using reason code 499.

4. DA-medical applications with an application date prior to July 1, 2003 as a result of a JFS 02453 - Inpatient Hospital Referral Form, must have their eligibility determined under the DA-medical rules that were in effect prior to July 1, 2003.

This information is also available on the Internet in MEMTL 8 and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM
MIL 03-001 (Mtg. Notice)

Medicaid Informational Letter: 03-001

January 3, 2003

To: Directors, County Departments of Job and Family Services

For: Income Maintenance Administrators/Supervisors/Trainers

From: Odella Coulter-Lyons, Manager
Office of Ohio Health Plans
Bureau of Consumer and Program Support
County Oversight and Support Section

Subject: Administrators / Supervisors Meeting Notice

In order to ensure consistent communication of policy updates and changes, the Covered Families and Children Medicaid (CFCM) Technical Assistance Unit has planned a series of regional meetings for administrators/supervisors/trainers who have a role in determining CFCM eligibility. Meetings are scheduled as follows:

<table>
<thead>
<tr>
<th>DATE</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td>Tuesday, February 4, 2003</td>
<td>Athens CDJFS, County Home, State Route 13, Athens</td>
</tr>
<tr>
<td>Wednesday, February 5, 2003</td>
<td>Franklin CTY. West Opportunity Center 314 N. Wilson Rd., Columbus</td>
</tr>
<tr>
<td>Thursday, February 6, 2003</td>
<td>Greene CDJFS 541 Ledbetter Rd., Xenia</td>
</tr>
<tr>
<td>Tuesday, February 11, 2003</td>
<td>Canton Regional Office, Lower Level Conference Rm. 401 Market Ave. N., Canton</td>
</tr>
<tr>
<td>Thursday, February 13, 2003</td>
<td>Geauga CDJFS 12480 Ravenwood Drive, Chardon</td>
</tr>
<tr>
<td>Wednesday, February 26, 2003</td>
<td>Hancock CDJFS 7814 County Road 140, Findlay</td>
</tr>
</tbody>
</table>

Meetings are scheduled to begin at 9:30 a.m. and will conclude at 3:00 p.m.. The entire meeting will be devoted to issues surrounding assistance group composition. Staff wishing to attend may choose the location that is most convenient for them as the same information will be shared at each of the meetings. In order to help us prepare sufficient materials, please complete the attached registration form and return it to me by January 31, 2003.

We look forward to having you in attendance at one of our meetings. Directions to each of the meeting locations are attached. If you have questions, feel free to contact me at 216-787-3880 or via GroupWise e-mail.

Certificates of attendance will be provided.

You will note that this letter represents the beginning of new system of sequentially numbered Medicaid Informational Letters (MIL=s) to CDJFS directors from our Bureau. The numbers will help you keep track of
written communications as they are issued. We are still refining some details, and we welcome your feedback and input as to how this new process can be helpful.

REGISTRATION FORM
COVERED FAMILIES AND CHILDREN MEDICAID
ADMINISTRATORS/SUPERVISORS MEETING

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DATE</th>
<th>NUMBER ATTENDING</th>
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<tr>
<td>Athens CDJFS</td>
<td>Tuesday, February 4, 2003</td>
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<td>Wednesday, February 26, 2003</td>
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</tbody>
</table>

FAX OR E-MAIL COMPLETED FORM BY JAN. 31, 2003 TO:
Odella Coulter-Lyons
Cleveland Field Office
FAX: 216-787-3299
Archived PALs
The following Public Assistance Letters are being provided for user convenience.
Public Assistance Letter (PAL) No. 877

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: THOMAS J. HAYES, DIRECTOR
SUBJECT: NEW FORMAT FOR MEDICAID CARDS

Effective May 1, 2002, the monthly Medicaid cards (also known as "medical cards") issued by the Ohio Department of Job and Family Services are being revised. The purpose of the new medical card format is to simplify the design, make the appearance more like medical cards issued by private insurance companies, and to clarify the cards' restrictions or uses. Samples of each card are attached including a card example with each field identified. The new cards will be mailed each month to all Medicaid-eligible consumers except those consumers who are enrolled in a managed care plan (MCP). The cards will list everyone who is in a specific assistance group (AG), up to seven people. If an AG has more than seven people, additional cards will be mailed as necessary.

The new cards will be issued on a limited basis in May 2002, after the recurring cards for May have been issued. Any auxiliary medical cards or supplemental medical cards issued between May 1, 2002 and May 31, 2002 will be in the new format. Beginning June 1, 2002, all medical cards will be in the new format, including the recurring cards for June 2002.

The following cards have been redesigned:

- Ohio Medicaid Card ("regular" Medicaid card)
- Disability Assistance Medical Card
- Healthy Start, Healthy Families Card (which includes MA C, MA P, and MA Y categories, among others)
- Disability Assistance Restricted Status Medical Card
- Primary Alternative Care and Treatment (PACT) Card
- Ohio Qualified Medicare Beneficiary (QMB) Card
- Expedited Medicaid Card

Additional information may also be obtained on the following website:
http://www.state.oh.us/odjfs/ohp/card.stm

HIGHLIGHTS OF CHANGES

Size and Appearance: The new Ohio medical cards will be printed on letter-size (8½” x 11”) paper. The actual card will be at the bottom of the page and will be perforated, enabling the consumer to easily remove it from the page. It can be folded in half and it will then be approximately the same size as a driver's license or credit card. Please note that the examples attached to this PAL are not printed on perforated paper.

Consumer Hotline: The toll-free number and the TDD number for the Ohio Medicaid Consumer Hotline will appear both on the page each card is printed on as well as on each card itself.

Messages Section: There will be an area on the page each card is printed on which is labeled "Messages." Periodically, non-case specific messages will appear under this heading. For example, if there is an policy change which results in expanded Medicaid coverage, a brief statement about it may appear under the "Messages" heading.

Important to note: It is important to note that the new cards will "work" exactly like the current/ "old" Medicaid cards. The appearance of the cards is changing; the use of the cards and the medical services covered by Medicaid are not changing with the release of the new cards. The cards will continue to be mailed monthly to eligible assistance groups except when an assistance group is enrolled in a managed care plan (MCP).
**Instructions:** Obsolete PAL 857.

**Attachments**

- Ohio Medicaid Card (color example with fields identified)
- Ohio Medicaid Card ("regular" Medicaid card)
- Disability Assistance Medical Card
- Healthy Start, Healthy Families Card (which includes MA C, MA P, and MA Y categories, among others)
- Disability Assistance Restricted Status Medical Card
- Primary Alternative Care and Treatment (PACT) Card
- Ohio Qualified Medicare Beneficiary (QMB) Card
- Expedited Medicaid Card
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: GREGORY MOODY, INTERIM DIRECTOR
SUBJECT: MMIS CASE CLOSURE PROCESS

Background:
An issue has been identified in which individuals' Medicaid assistance cases had been properly terminated in CRIS-E or FACSIS but the information was not received by the Medicaid Management Information System (MMIS). Although the CRIS-E or FACSIS cases were properly closed and these individuals no longer received a Medicaid health card, MMIS continued to show an open eligibility span.

The systems errors that accounted for this problem have been identified and corrected. However, as a result of this problem, there are approximately 5,140 CRIS-E individuals and 1,300 FACSIS individuals who continued to have their Medicaid claims paid after their CRIS-E or FACSIS case was closed. These claims were paid because the individual's provider sent in a bill using the client's Medicaid billing number from their records. To properly close the eligibility spans in MMIS a number of actions will be taken.

All affected individuals can be identified on the MMIS Recipient Master File (RMF) with an Administrative error code of "M." This code will permanently identify these individuals. Any extension of this eligibility span will also be identified with the "M."

Current action:
Medicaid regulations require that a pre-termination review (PTR) of the individual's eligibility must be completed prior to closing these cases. In order to accomplish the PTR, ODJFS initiated the following activities:

1. A pre-termination review letter was sent by ODJFS to each affected individual to their last known address. A forwarding order was requested.

   The letter states that although their case was closed and they no longer received a Medicaid card, claims continued to be paid because of the systems error. The error is not the individual's fault and the department is not requesting that the individual or provider reimburse the department.

   The letter also states that the department does not have enough information to determine their continued eligibility for Medicaid. In order for the individual to continue to get Medicaid they must contact their local county department of job and family services (CDJFS), and file an application by May 01, 2001. If they do not file an application by this date, a notice will be issued proposing to terminate the MMIS eligibility span.

2. For those individuals who file an application on or before the deadline date, the MMIS span will remain open until an eligibility determination has been made.

3. For those individuals who request a timely hearing, the MMIS span will remain open until a state hearing decision has been issued.

ODJFS Activities:

1. A file was sent to each CDJFS identifying the affected individuals who had been residing in their county at the time their case was closed.

2. Issue the initial (PTR) letter to all affected CRIS-E and FACSIS individuals. A copy of the initial letter is attached.

3. Issue prior notice to individuals who do not respond to the initial letter or for whom mail is returned as undeliverable.
(4) Notify MMIS staff of those individuals who are to have the eligibility spans terminated and the date that the termination is to be effective.

(5) Notify MMIS staff of those individuals who are to have the eligibility spans extended.

(6) Issue an on-line CRIS-E View Flash Bulletin.

(7) Track these individuals to match them against CRIS-E pending/open/denied cases. A report will be generated by CRIS-E to identify these individuals.

CDJFS Activities:
(1) Process the applications in accordance with OAC rules.

(2) Represent the department at any state hearings on this issue.

Attachment

April 2001 Information Letter

the April 2001 Information Letter.
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS  
FROM: JACQUELINE ROMER-SENSKY, DIRECTOR  
SUBJECT: OHIO FAMILY MEDICAL PROJECT  

BACKGROUND:  
Over the past few years Ohio has made significant progress in increasing access to health care coverage for low-income, working families. As a result of eligibility expansions, simplified enrollment procedures, and various outreach campaigns, thousands more low-income children and parents are eligible for health care coverage through Medicaid.

The delinking of Medicaid from cash assistance as a result of changes in federal and state laws and regulations has made it possible for Ohio to offer low-income families health care coverage regardless of whether the family is receiving Ohio Works First (OWF) cash assistance. The Health Care Financing Administration (HCFA) is concerned that some families who left the OWF program as a result of Welfare Reform may have lost Medicaid coverage for which they should have remained eligible.

As a result, on April 7, 2000, HCFA issued a letter to all states related to the following three topics:

- A series of actions that all states must take to identify individuals and families who may have been terminated improperly and to reinstate them to Medicaid.
- To clarify guidance on federal requirements relating to the process for redetermining Medicaid eligibility. 
- Review the obligations imposed by federal law with regard to the operation of computerized eligibility systems.

Ohio's response to the directives in HCFA's April 7, 2000 letter was to create the Ohio Family Medical Project. This project consists of two parts. The first part provides a "no strings attached" Medicaid health card for three months of Medicaid coverage and an application packet that includes a simplified application which will be reviewed for ongoing coverage after the three month Medicaid coverage ends. The second part of the project is to provide an opportunity for individuals to have their eligibility determined for reimbursement and/or payment of medical bills that they incurred during the period of time that they were not receiving Medicaid but fell within the targeted population of individuals who may have been inappropriately terminated from Medicaid.

The Office of Ohio Health Plans in the Ohio Department of Job and Family Services is responsible for the Ohio Family Medical Project (OFMP). The address for the project is: P.O. Box 182399, Columbus, OH 43272-3393. The phone number is 1-888-221-1560.

PART I

REINSTatement FOR IMPROPER MEDICAID TERMINATIONS

HCFA requires that individuals, who may have been inappropriately terminated from Medicaid since the state's OWF plan went into effect, be reinstated for Medicaid coverage and that the state conduct follow-up eligibility reviews as appropriate.

Ohio has opted to define a class of individuals potentially inappropriately terminated rather than conduct individual case reviews to make a determination of the appropriateness of every termination.

Affected Individuals and Assistance Groups:

The universe of persons eligible for reinstatement consists of all persons terminated from MA-C, except those whose termination involved a select number of termination codes that the department has determined were definitely appropriately used (e.g., death of only eligible assistance group member, entire assistance group moved out of state, those immediately enrolled in Transitional Medicaid or other Medicaid coverage) and
those were receiving some form of Medicaid in August 2000. The original number of individuals included in this population was approximately 160,000 individuals. The number who were mailed the January 1, 2001 - March 31, 2001 Medicaid card was 133,040. (This number reflects the members of the original universe after factoring out unlocatable individuals and individuals who chose not to be reinstated.)

Look-back Period:
The look-back period chosen for this project is November 1, 1997 through April 30, 2000. This period starts when Ohio's welfare reform policies would begin to affect eligibility determinations for Medicaid and ends six months after the introduction in November 1999 of Ohio's pre-termination reviews of continuing Medicaid eligibility policy (PTR).

Length of Reinstatement Period:
The reinstatement period will be three calendar months: January 1, 2001 through March 31, 2001. However, if any of the approximately 25,000 individuals who are currently unlocatable become known to ODJFS on or before December 31, 2001, they will be eligible for a 3 month reinstatement period and a period of time to request and submit applications for continuing benefits and/or past medical bills reimbursement.

REINSTATEMENT PROCESS:
During the first week of November 2000 an information letter (Attachment 1) and update form (Attachment 2) were mailed to each individual identified in the reinstatement universe. The letter informs each individual that they will receive a Medicaid card that will provide three months of Medicaid with no strings attached. The update form provides an opportunity for individuals to either update their address or decline the three month Medicaid card and to be removed from future mailings regarding the Ohio Family Medical Project.

- The 3-month Medicaid card is issued on an individual basis to each person identified as belonging to the reinstatement universe. When there are several family members within the same household who are also receiving mailings regarding this project each family member receives his/her own 3-month Medicaid card.

- The Medicaid card shows a three month span of eligibility. Only one card is issued for the three month period. Replacement cards for lost/destroyed cards are available through the OFMP project. Individuals must call the toll free number (1-888-221-1560) to request a replacement card.

- These individuals will not be enrolled in managed care, including those who reside in a mandatory managed care county. This is a fee-for-service Medicaid card.

- There are approximately 15,000 individuals who are part of the reinstatement population who applied and were approved for Medicaid on or after September 1, 2000 and were in receipt of Medicaid in January 2001. These individuals will receive two Medicaid cards for each, or all three months of the reinstatement period. They will receive their regular Medicaid card that is issued for the entire assistance group, and then each individual in the reinstatement population will receive the 3-month Medicaid card. These individuals may use either card during the 3 month period.

- Individuals who are currently in receipt of Medicaid and are enrolled in managed care are still eligible to use the three month Medicaid card. However, they are encouraged to continue to use their managed care provider in order to maintain their continuity of care. A letter was sent to individuals who received the 3-month Medicaid card and are currently enrolled in a managed care plan advising them to continue to see their primary care provider.

- Individuals will not be asked to repay for any services received during the three months of coverage even if they are later found ineligible for continued Medicaid coverage.

- Providers have been notified that these unique cards will be in circulation for a limited time, and that all Medicaid policy/procedures and billing instructions for these cards are consistent with normal Medicaid coverage billing.

Prior authorization requirements must still be met for those medical services that must be prior authorized. On or about December 20, 2000, the three month Medicaid card (Attachment 3) was mailed. In a separate mailing, an application packet (Attachment 4) was also sent. The application packet includes a simplified
application for a determination of Healthy Start/Healthy Families coverage, instructions and a return envelope. The application includes a section requesting information on whether an individual has a disability. If the individual indicates that someone named on the application has a disability, the CDJFS must contact the individual and explore eligibility under Medicaid for persons with a disability. The packet also includes information about the payment of past medical bills and other ODJFS support services.

A reminder notice (Appendix 5) was sent the third week of January 2001 to remind individuals to send in the application as soon as possible to insure continuous health coverage.

A final notice will be sent in early March 2001 to again remind individuals that the reinstatement period ends March 31, 2001. The notice will also tell them that they can apply for coverage any time in the future through the usual application process. This notice will be a prior notice that benefits will be ending effective March 31, 2001 and also notifies individuals of their right to request a state hearing. The notice advises the individual to return the hearing request mailer to the Bureau of State Hearings. If the individual contacts the CDJFS to request a state hearing, the CDJFS must immediately forward the request to the Bureau of State Hearings office.

**TRANSITIONAL MEDICAID**

Reinstated families who do not submit an application during the reinstatement period lose eligibility at the end of March 2001. There is no Transitional Medicaid eligibility for this group.

Reinstated families who apply and are over income for MA-C during the entire reinstatement period are not eligible for Transitional Medicaid at the end of the reinstatement period.

Reinstated families who apply and who are income eligible in January 2001, but who experience an increase in earned income during the reinstatement period which makes them ineligible in April are eligible for Transitional Medicaid (MA-Y). The beginning date of MA-Y eligibility will be April 1, 2001. CRIS-E instructions to open an MA-Y assistance group will be issued through an on-line View Flash Bulletin.

**PREGNANT WOMEN**

Reinstated women who are, or become pregnant, during the reinstatement period, must file an application for continued benefits. Individuals who do not submit an application during the reinstatement period lose eligibility at the end of March 2001. Women who complete the application are eligible for coverage throughout their pregnancy and post-partum period regardless of their financial eligibility for continued Medicaid.

**NEWBORNS**

A child born to a woman during the reinstatement period is eligible for Medicaid per OAC rule 5101:1-40-022. If the CDJFS is aware that the woman has given birth, they must contact the woman and attempt to get her to complete an application during the reinstatement period. However, regardless of whether an application is filed, the newborn will be deemed eligible for Medicaid for one year. The CDJFS shall immediately take action to open a case in CRIS-E upon notification of a child born to a woman during the reinstatement period. If an application has not been filed, the CDJFS must document in CLRC that the child was deemed eligible for Medicaid as a result of the Ohio Family Medical Project.

**Ohio Family Medical Project Office Responsibilities**

To be reviewed for ongoing eligibility, the assistance group will complete one Ohio Family Medical Project application for the entire assistance group even though an application packet had been sent to each individual. The assistance group will be instructed to return the completed, signed and dated application along with proof of current monthly income to a central P.O. Box (A business reply envelope was included with the application packet.). This P.O. Box is being managed out of the OFMP office.

- Signed applications received by OFMP will be date stamped and logged into the OFMP’ database and then forwarded to the OFMP Coordinator in the assistance group' current county of residence.
- The date a signed application is received by the Ohio Family Medical Project (OFMP) office will be the protected date of application even though the application may not be received by the CDJFS until several days later.
A receipt (Attachment 6) will be sent by the OFMP office to applicants informing them that their application has been received and has been forwarded to their local CDJFS for review.

Applications received by the OFMP office without a signature will be returned to the assistance group for completion. A business reply envelope will be included for them to return the completed application. The protected date of application will be the date the signed application is returned to the OFMP office. The application will be date stamped and logged into the OFMP’s database and then forwarded to the OFMP Coordinator in the assistance group’s current county of residence. A receipt will be sent to the assistance group. The receipt will also tell the assistance group to which county the application was forwarded.

Assistance groups will also be able to have their eligibility for retroactive health care coverage explored. The application includes information for reviewing retroactive eligibility for up to three months prior to the month of application.

If an individual loses his/her Medicaid card, they will need to contact the OFMP office to request a replacement. The CDJFS cannot authorize a replacement card through CRIS-E.

CDJFS Responsibilities

Each CDJFS must have an OFMP coordinator. All correspondence (applications, etc.) will be sent to the CDJFS coordinator who will assign the work within the agency and track its progress.

Upon receipt of the application from the OFMP office, the CDJFS will register the application within CRIS-E using the date the application was received by the OFMP office as the application date.

The CDJFS will process the application in accordance with the application processing rules as delineated in Chapters 7000 and 11000 of the Public Assistance Manual.

The CDJFS shall enter the application information into CRIS-E and authorize the case as usual based on the beginning date of eligibility, without regard to the 3 month Medicaid card. Due to the receipt of the 3-month Medicaid card, if the assistance group is determined eligible for Medicaid, the beginning date of regular Medicaid eligibility will be April 1, 2001.

If the CDJFS receives an OFMP Healthy Start/Healthy Families application directly from an individual rather than from the OFMP office, the CDJFS's OFMP coordinator must contact the OFMP office to report receipt of the application. The OFMP office will determine if the individual is a member of the universe of individuals that is part of the OFMP.

The CDJFS shall explore retroactive coverage when necessary for the three months prior to the month the application was submitted (Section G on the OFMP Application for Health Coverage). If the individual presents medical bills that fall outside of the three month retroactive period but falls within the look-back period (November 1, 1997 through April 30, 2000), the eligibility worker must call the OFMP office and request that a PMB application be sent to the individual for completion.

For assistance groups who already have an application for assistance pending, the CDJFS shall continue to process the application that has already been filed. The receipt of the 3-month Medicaid card will not have any impact on the determination of eligibility based on an application already pending.

Individuals who are approved for ongoing assistance will not be required to be enrolled in managed care, in those counties in which managed care is mandatory, until after March 31, 2001.

Individuals who are reinstated for a 3-month period other than January 1, 2001 through March 31, 2001 and receive a 3-month Medicaid card and are subsequently approved for ongoing coverage, will not be required to be enrolled in managed care, in those counties in which managed care is mandatory, until after the 3-month Medicaid card has expired.

The CDJFS must document in CLRC the action taken on applications that have been issued as part of the OFMP.

PART II
REIMBURSEMENT OF PAST MEDICAL BILLS

Many of the individuals and families who were terminated from MA-C during this period of time will have incurred medical bills that would have been covered under Medicaid had they continued to be eligible. As part of the Ohio Family Medical Project, procedures have been established for individuals who were in the identified population to request reimbursement and/or payment of past medical expenses.

There are two groups of individuals who are eligible to apply for reimbursement and/or payment of their past medical bills. The first group are those individuals who were also eligible to receive the 3-month Medicaid card. The second group are those individuals who were in the identified population but were not eligible for reinstatement because they were in receipt of Medicaid in August, 2000.

The application packet that was sent out in mid-December 2000 to the individuals eligible for reinstatement included an information sheet (Attachment 4) entitled "Information on How to Get Payment of Past Medical Bills."

A separate information sheet (Attachment 7) was sent to approximately 52,000 individuals in January 2001 who are potentially eligible for reimbursement or payment of past medical bills but were not eligible for the 3 month Medicaid card.

If the individual is determined eligible for coverage of past medical bills, ODJFS will either directly reimburse the individual for bills that have already been paid by the recipient, or notify the provider that he/she can bill Medicaid for the service.

To obtain an application for payment of past medical bills (Attachment 8) the individual must call the Ohio Family Medical Project at 1-888-221-1560 by March 31, 2001 and request a Past Medical Bills (PMB) Application. The completed application must be returned to the OFMP office by April 30, 2001. These dates will be adjusted appropriately for unlocatable people who are later identified on or before December 31, 2001.

For PMB applications that are issued by anyone other than the Ohio Family Medical Project office, the issuer must advise the individual that he/she must still call the Ohio Family Medical Project toll-free number on or before March 31, 2001 to register his/her name in order to have his/her eligibility for reimbursement and/or payment of past medical bills explored.

Claims for payment submitted by providers will be returned to the provider. This review process can only be initiated by an individual in the identified population.

Eligibility Requirements:

The individual requesting reimbursement and/or payment of past medical bills must meet the following eligibility criteria:

- The individual must be on the statewide lists of the "reinstatement" and past medical bills only" groups provided by ODJFS to the CDJFSs of the individuals who are eligible to have their eligibility determined for reimbursement and/or payment of past medical bills. (The OFMP office will review the list to ensure that the individual meets the criteria.)

- The individual would have been eligible under a category of Covered Families and Children Medicaid (e.g. Low-Income Families/Healthy Families (MA-C), Healthy Start (MA-P), or Transitional Benefits (MA-Y), MA-T (Children under 21), 4-Month Extended, etc.) categories of Medicaid at the time the medical bill was incurred. Eligibility must be determined based on the assistance group composition and eligibility requirements (financial and non-financial) that were in effect for the month the medical service was received.

- Persons who became a member of an eligible individual's household after the Medicaid case was closed, are not eligible for reimbursement or payment of medical expenses. However, this person's income and relationship will be considered when determining whether eligibility exists for PMB for the other members of the household who are part of the OFMP universe.

- Medical bills for individuals who are not part of the OFMP universe shall not be considered. Exceptions: 1) If the individual and CDJFS can establish to the OFMP office that the individual should have been included in the universe. 2) A child whose mother is part of the universe and it can be
established that the mother was pregnant in the month the Medicaid case was closed. The child will be included as part of the universe from the date of birth. However, in order for the child's eligibility for reimbursement or payment to be considered, a PMB application must be completed and returned.

- In the notices sent to individuals that provided information about past medical expenses, individuals were requested to contact the OFMP office and request a PMB application packet on or before March 31, 2001. A PMB application should be requested as soon as possible so that the individual can meet the April 30, 2001 deadline for filing the application. Reference the section on unlocatable individuals who are identified on or prior to December 31, 2001 for information on their opportunity to apply for payment and/or reimbursement.

- A separate PMB application must be completed for each individual for whom reimbursement or payment is requested.

- Proof of income for the assistance group, as the assistance group existed in the month the medical service was received.

- Proof that the medical services were received and paid, or that money is still owed.

- The individual must submit a signed application on or before the April 30, 2001 deadline even if they are unable to obtain the income and/or medical bills verification that is required.

- The assistance group must be income-eligible for Medicaid in the month that the medical services were received before the individual within the assistance group can be reimbursed or the bill paid.

- The medical bill must be for medical services that Medicaid covers. For medical services that require prior authorization, medical necessity must still be established before the medical expense can be reimbursed or paid.

- The OFMP office will determine the amount of the reimbursement requested.

- Medical bills must have been incurred after the MA-C Medicaid was terminated any time after November 1, 1997 and on or prior to September 30, 2000. Bills that were incurred during any period of Medicaid eligibility for which an eligibility span already exists will not be considered for reimbursement. Bills that were incurred after an individual was terminated from any category of Medicaid other than MA-C will not be considered for payment or reimbursement. The OFMP office will determine whether the individual is in this group.

- For individuals who are eligible as part of the "past medical expenses only" group (described above), the medical bills must have been incurred after their MA-C Medicaid was terminated at any time after November 1, 1997 and on or prior to April 30, 2000. Bills that were incurred during any period of Medicaid eligibility for which an eligibility span already exists will not be considered for reimbursement. Bills that were incurred after an individual was terminated from any category of Medicaid other than MA-C will not be considered for payment or reimbursement. The OFMP office will determine whether the individual is in this group.

- Individuals whose medical bills were incurred after their Medicaid assistance under a category of Medicaid other than MA-C was terminated or denied, are not eligible for reimbursement or payment of those bills.

- Hospital bills that have already been charged to HCAP (Hospital Care Assurance Program) will not be considered for payment as a past medical bill.

- The PMB application is not an application for any other type of assistance. However, if it appears that the individual may have eligibility for Medicaid in any category, an application (APPL or CPA) should be sent to the individual to be completed and returned to their county department of job and family services.

**ODJFS Responsibilities - Issuing an Application**

To be reviewed for reimbursement or payment of past medical bills the individual must call the OFMP office at 1-888-221-1560 and request an application.
The OFMP office will verify that the individual is included in the OFMP universe.

The OFMP office will send out an application packet for each individual for whom reimbursement and/or payment is requested. Included in the application packet will be a cover letter, application, and a business reply envelope.

The OFMP office will track all application packets being sent out.

The individual is instructed to return the application and documentation to the OFMP office.

The returned applications will be date stamped and logged into the OFMP's database. The application is then screened by ODJFS to determine if the medical bills fall within the covered period. The application will also be reviewed to determine if the individual (assistance group) would have been potentially eligible, other than financially, for Medicaid under Covered Families and Children Medicaid at the time the medical service was provided.

If it is determined that the individual would not have been eligible under any category of Covered Families and Children Medicaid, the application will not be forwarded to the CDJFS. A denial notice (Attachment 9) will be issued by the Ohio Family Medical Project office.

If the individual was potentially eligible under a category of Covered Families and Children Medicaid, the application will be forwarded to the CDJFS's OFMP coordinator in the assistance group's current county of residence for review of the assistance group's financial eligibility for the month(s) that the medical services were received.

**CDJFS Responsibilities B Receipt and Review of an Application**

The CDJFS will be responsible for processing the PMB application, contacting the assistance group if additional information is needed, and determining if the individual (assistance group) is financially eligible under a Covered Families and Children category in the month the medical services were received. The CDJFS will not be responsible for determining medical necessity or whether the service was a Medicaid-covered service.

- The application for reimbursement or payment of medical bills will not be processed through CRIS-E.
- The CDJFS shall use the income eligibility standards for the assistance group size that were in effect at the time the medical services were received. A listing of the standards that were in effect at various times during the period November 1, 1997 through September 30, 2000 are included as an attachment (Attachment 10) to this PAL.
- The CDJFS shall use the usual application processing standards when reviewing eligibility for the period in question (e.g., verification request checklist and follow-up letter, signed release forms, etc.). The CDJFS must send a verification request check list to the assistance group if additional verification and/or information is necessary in order to determine eligibility.
- The CDJFS shall not determine if the termination of prior Medicaid assistance was correct or incorrect. The correctness of the termination is not a factor for consideration in determining eligibility for payment of past medical expenses.
- Because applications may be received directly by the CDJFS, the CDJFS’s OFMP Coordinator will need to contact the OFMP office to report the direct receipt of the application in order to determine if the individual is a member of the universe of individuals that is part of the OFMP.
- The CDJFS must also determine who were members of the assistance group at the time the medical services were received. This impacts income eligibility.
- For income verification, the CDJFS shall refer to OAC rule 5101:1-38-02. The CDJFS must offer to help the assistance group obtain any necessary verification if assistance is requested. Verification is needed for each individual within the assistance group that reports receiving income from any source. The application has a section that asks if assistance is required to obtain proof of income.
- In order for a past medical expense to be considered, the CDJFS must have verification from the individual of each of the following items for each bill that is submitted for consideration:
• Date of service
• The type of service received (e.g., dental-filling, pharmacy-name of drug, or supplies, doctor-illness, treatment, etc.)
• The total amount billed, amount paid, amount still owed, and if any of the bill was paid by medical insurance

The CDJFS must offer to help the assistance group obtain any necessary verification if assistance is requested. The application has a section that asks if assistance is required to obtain proof of medical bills.

- Verification of income and the medical expense must be verified for each month that the individual presents a medical expense.
- The CDJFS must determine if the assistance group was financially eligible for each month for which the individual has submitted past medical bills.
- For any months in which the individual is not financially eligible for reimbursement or payment of his/her medical expenses, the CDJFS must send the individual a denial notice (Attachment 10) that gives the reason for denying the bill(s) for a particular month. A copy of the denial notice must also be sent to the OFMP office P.O. Box.
- For any month in which the individual/assistance group fails to cooperate, after they have been properly notified of the verification that is required to determine eligibility, the request for reimbursement and/or payment shall be denied.
- For any months in which the individual is financially eligible for reimbursement or payment, the CDJFS OFMP Coordinator shall submit the entire PMB application packet and documentation to the OFMP P.O. Box for final approval.

The PMB packet that is submitted to the OFMP office must include all of the following:

- Recommendation letter from the CDJFS. (Attachment 11)
- Completed and signed PMB application.
- Proof of income for all assistance group members for each month for which medical bills were submitted.
- Proof medical services were received (including date of service, type of service, provider, provider's address, amount charged).
- Proof that the bill is paid (amount of original bill and amount paid) or proof that the bill has not been paid (amount of original bill, and amount paid, if any, and amount still owed)
- A budget worksheet for each month.

**ODJFS's Responsibilities - Receipt of PMB Packet for Approval**

The ODJFS will be responsible for determining the final approval for reimbursement and/or payment of medical bills for an individual. Upon receipt of the application package from the CDJFS, the OFMP office will review the application package to determine the following:

- For **paid and unpaid** medical bills, determine if the medical service was a Medicaid-covered service at the time the service was received.
- Determine if the service was medically necessary.
- Determine if the medical service would have required prior authorization.
- Confirm that the individual was not in receipt of Medicaid at the time the medical services were provided.

**Paid Medical Bills:**

- Verify if the service was a Medicaid-covered service.
• For paid medical bills, the provider is not required to be a Medicaid provider.
• Determine the amount to be reimbursed for a medical service.
• Determine if Medicaid had already paid for the service while the individual was in receipt of Medicaid. If the service had already been paid by Medicaid within the period the service was intended to cover, the request for reimbursement will be denied.
• For medical services that require prior authorization, review the service for medical necessity.
• Contact the provider if additional medical information is necessary to determine the medical necessity for the service.
• Verify that the total that is to be reimbursed is correct.
• Submit request for reimbursement to the Office of Fiscal Services.
• The OFMP office will issue an approval letter to the individual. (Attachment 12)
• The OFMP office will issue a denial letter (Attachment 11) if the individual is not eligible to have the service reimbursed, or not reimbursed for the total amount paid.
• The OFMP office will enter the final approval and denial information into CRIS-E Running Record Comments (CLRC) and return the entire application packet to the CDJFS Coordinator.

Unpaid medical bills:
• Determine if the provider was a Medicaid provider at the time the service(s) was provided and if the provider is currently a Medicaid provider. Requests for payment will be denied if the provider was not a Medicaid provider at the time the medical service was rendered and is not also currently a Medicaid provider unless the provider is willing and able to enter into a provider agreement. In some circumstances, a provider agreement may be retroactive for up to one year.
• For medical services that require prior authorization, review the service for medical necessity. Contact the provider if additional medical information is necessary to determine the medical necessity for the service.
• Contact the provider, if additional medical information is necessary to determine whether the medical service(s) can be paid for through Medicaid.
• If approved, notify the provider that the individual is eligible for Medicaid to cover all, or part, of the bill. The notice to the provider will advise them that they must hard copy bill the department, include a copy of the notice to the provider, and submit the bill to the OFMP office. The provider must return the requested forms within 60 days of the date on the letter to the OFMP office in the business reply envelope that is provided with the notice. The notice will also advise the provider that they can bill Medicaid for the specific date(s) of service even though the date of service is older than 365 days from the date of billing.
• The provider will be paid at the current Medicaid rate for the type of service provided.
• Upon receipt of the claim form(s), the OFMP office will request that an eligibility span be entered for the service date only in the Recipient Master File (RMF).
• After the eligibility span has been entered into the RMF, the bill will be forwarded to the Bureau of Plan Operations. Staff in this bureau will process the claim for payment to the provider.
• The OFMP office will issue the approval notice to the individual.
• The OFMP office will issue a denial notice if the request for payment is denied.
• The OFMP office will enter the final approval information into CRIS-E Running Record Comments (CLRC) and return the entire application packet to the CDJFS Coordinator.

ADDITIONAL NOTES:
For unpaid bills, if the provider chooses not to submit a claim for payment of a Medicaid-covered service, the ODJFS will not reimburse the individual. The individual will continue to remain responsible for the bill. However, if the individual chooses to pay the provider and submit a request for reimbursement, the request for reimbursement will be considered if the request is received within 90 days of the date the notice was sent to the provider. After that time, no reimbursement will be considered.

The OFMP will not consider any interest charges, late fees, collection fees, etc. that may have accrued since the medical service was received. The Medicaid program will only consider for payment the Medicaid rate for the service. This payment constitutes payment in full per the Ohio Medicaid provider agreement.

For bills that have been partially paid, the OFMP will reimburse the individual up to the amount paid. The provider may bill the balance; however, the OFMP will only consider for payment, the remaining unpaid amount up to the Medicaid rate less the amount already paid by the individual.

UNLOCATABLE INDIVIDUALS

Individuals who are part of the OFMP reinstatement universe but could not be located, will be provided an opportunity to receive a 3-month Medicaid card and review of their past medical bills.

- These individuals must identify themselves to the OFMP office on, or prior to December 31, 2001. If eligible, they will receive a 3 month Medicaid card. (Attachment 13)
- The individual may choose to have the 3 month period beginning the month they identified themselves to the OFMP or for a 3 month period beginning the month following the month they were located and identified.
- An application packet (Attachment 4) will be issued at the time the Medicaid card is issued.
- The individual will have until the end of the 3-month period of Medicaid eligibility to request a Past Medical Bills Application (PMB) packet.
- The PMB application must be returned by the end of the month following the month the 3-month Medicaid eligibility ends.

INDIVIDUALS WHO ARE PART OF THE OFMP UNIVERSE THAT ARE ONLY ELIGIBLE TO HAVE THEIR ELIGIBILITY DETERMINED FOR REIMBURSEMENT AND/OR PAYMENT OF PAST MEDICAL BILLS

- Will have until the end of the month following the month they identified themselves to the OFMP to complete and return a PMB application.
- The same eligibility requirements and application processing standards apply to these individuals.

NOTE: None of the attached forms will be available through the ODJFS Warehouse. The PMB Denial Notice and Recommendation Letter from the CDJFS forms must be reproduced by the CDJFS.

ATTACHMENTS:

1. November 2000 Information Letter
   Click here to view the November 2000 Information Letter.

2. OFMP Update Form
   Click here to view the OFMP Update Form.

3. 3-Month Medicaid card
   Click here to view the 3-Month Medicaid card.

4. OFMP Application Packet
   Click here to view the OFMP Application Packet.

5. Reminder Notice
   Click here to view the Reminder Notice.
6) Receipt
Click here to view the Receipt.

7) PMB Information Notice
Click here to view the PMB Information Notice.

8) PMB Application packet
Click here to view the PMB Application packet.

9) PMB Denial Notice
Click here to view the PMB Denial Notice.

10) Financial Eligibility Standards
Click here to view the Financial Eligibility Standards.

11) Recommendation Letter from CDJFS
Click here to view the Recommendation Letter from CDJFS.

12) Approval Letter
Click here to view the Approval Letter.

13) OFMP Flyer
Click here to view the OFMP Flyer.
Public Assistance Letter No. 868-A

Click here to view the Public Assistance Letter No. 868-A, Subject: Cost of Living Allowance (COLA) Increases and Long Term Care Facility Assistance Groups (Effective January 1, 1997).
Archived PAMTLs
The following Public Assistance Transmittal Letters are being provided for user convenience.
TO:        ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM:     THOMAS J. HAYES, DIRECTOR
SUBJECT: Medicaid and Covered Families and Children Medicaid: income, non-recurring lump-sum, exempt income, unearned income, resources; medicaid: living arrangement requirement, residence, cooperation in obtaining third-party and medical-support payments, CDHS/CSEA interface; OWF/DA/Medicaid: medical support

This MTL transmits changes with the proposed effective date of January 1, 2003. This cover letter includes a summary of each policy change. The rules were reviewed through the following clearance control numbers: 4768, 4772, 4849, and 4625. This transmittal will obsolete some Public Assistance Manual (PAM) sections in Chapter 11000 which are not in Ohio Administrative Code format.

Rules in this MTL reflect the establishment of a Medicaid stand-alone rule regarding the assignment of third-party and medical-support payments, right of recovery of third party resources and the role of ODJFS in the CDJFS regarding third party resources. This transmittal clarifies that all third parties must make payment for medical care to the maximum extent of their liability before medicaid funds may be used to pay providers for covered services. Application for or acceptance of medicaid constitutes an automatic assignment to ODJFS by the applicant and recipient, and also the rights of any other member of the assistance group for whom the applicant and/or recipient, can legally make an assignment.

Also contained in this transmittal are other clarifications that reflect the recission of the non-recurring lump sum policy, which was effective March 1, 2001, and issued via ACT #208; clarifications to state that child support payment distributions made by ODJFS pursuant to Division (C) of Section 1 of Am. S.B. 170 of the 124th General Assembly shall be excluded from consideration as income or resources in the financial eligibility determination for CFC medicaid.

Additional rules contained in this transmittal include minor revisions to living arrangement requirement, residence, and the recission of CDHS/CSEA interface.

CHAPTER 4000


This rule is shared between the Public Assistance Manual and the Cash Assistance Manual (CAM) and is maintained in CAM. This rule is being rescinded. It will be reissued as 5101:1-38-02.2. Please reference Cash Assistance MTL #6 (CAMTL 6).

CHAPTER 5000

Rule 5101:1-5-10: "DA: Nonfinancial Eligibility Requirements."

This rule is shared between the Public Assistance Manual and the CAM and is maintained in CAM. This rule is being amended to state that the requirements in rule 5101:1-38-02.2 are also applicable to the DA Medical Program. Please reference Cash Assistance MTL #6 (CAMTL 6).

CHAPTER 7000

There are no significant changes in the content of the rule.
There are no significant changes in the content of the rule other than to remove references to interstate residency agreements.

This rule is being rescinded. The cooperation requirements of this rule have been moved into proposed rule 5101:1-38-02.2.


This rule is being rescinded.


This new rule replaces contents formerly contained in rules 5101:1-1-20, 5101:1-39-56.1, and 5101:1-39-75.2. Please note that rules 5101:1-1-20 and 5101:1-39-56.1 are rescinded with this MTL and that rule 5101:1-39-75.2 "ADC-related medicaid: mandatory cooperation in securing child support and medical support" was rescinded with MTL 418.

CHAPTER 11000

5101:1-40-20 - Covered families and children (CFC) medicaid: income.

This rule is being amended to change language affected by the rescission of the non-recurring lump sum policy, which was effective March 1, 2001, and issued via ACT #208. Additional changes include clarification at paragraph (A)(2) that CFC Medicaid assistance groups must report increases in income within 10 calendar days of the increase, but that the budget adjustment does not become effective until the first day of the month following the month in which the assistance group receives the increased earned income; clarification in Paragraph (A)(4) regarding circumstances in which income is to be apportioned to future months; clarification in Paragraph (A)(8) to state that the income and resources of a supplemental security income (SSI) recipient excluded from the CFC assistance group due to receipt of SSI are not countable to the remaining members of the CFC assistance group; clarification in Paragraph (A)(9) regarding income and resources of parents excluded from the CFC assistance group; inclusion of language regarding foster care maintenance in Paragraph (A)(10); removal of language in Paragraph (A) (10) regarding sanctioned individuals; inclusion of language in paragraph (B)(1)(c) to state that an individual who is a recipient of SSI may choose to continue to receive SSI or terminate SSI and instead receive Healthy Families/LIF; and inclusion of language in Paragraph (E) regarding the effective date for income changes.

5101:1-23-07.5 - Healthy start: non-recurring lump-sum period of ineligibility.

This rule is being rescinded. This rule set forth the policy governing the treatment of non-recurring lump sum payments and included provisions for the calculation of future periods of ineligibility.

5101:1-40-20.1 - Covered families and children (CFC) medicaid: exempt income,
5101:1-40-20.3 - Covered families and children (CFC) medicaid: unearned income and
5101:1-40-14 - Covered families and children (CFC) medicaid: resources: application, definitions, availability, and limitations.

These rules are being amended to add language to state that child support payment distributions made by ODJFS pursuant to Division (C) of Section 1 of Am. S.B. 170 of the 124th General Assembly and Rules 5101:1-29-31.1 and 5101:1-29-31.2 of the Ohio Administrative Code shall be excluded from consideration as income or resources in the financial eligibility determination for CFC medicaid.

The following chart identifies the materials that are to be removed from the Public Assistance Manual (PAM), Chapters 7000 and 11000 and instructions for replacement, when applicable.

**Instructions:**

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<td>ACT No.208, &quot;OWF and Covered Families and Children (CFC) Medicaid: Immediate Rescission of the Non-</td>
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PAMTL 433
Public Assistance Manual Transmittal Letter No. 433
November 14, 2002

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: THOMAS HAYES, DIRECTOR
SUBJECT: MEDICAID

This cover letter includes a summary statement of each policy change. These rules have been through the clearance process.

This MTL and rules can be accessed through the following ODJFS E-Manuals Available On-Line at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb. The PAM is currently located on DynaWeb in the Family Stability collection.

As part of the ongoing process of converting from the PAM format to an OAC rule format, all of the PAM Sections in Chapter 7000 are being obsoleted and replaced with the current rule. As a result, there are a number of rules that have not been through the clearance process and have not had any changes made to the rule.

NOTE: Rules that state "No changes to this rule" are being included in this MTL so all PAM Sections in Chapter 7000 can be obsoleted and replaced with the applicable rule.

The rules were reviewed through the following clearance control numbers: 4729, 4731, 4745, 4749, 4803, 4828 and 4839.

CHAPTERS 1000, 2000, 4000, 6000 and 7000

As part of the ongoing process of creating a Medicaid specific manual that will include the Medicaid eligibility criteria for all Medicaid programs, chapter 5101:1-37 has been assigned to Medicaid. This chapter will include the general administrative policies for all categories of Medicaid. Until all chapters in the Public Assistance Manual have been fully converted to the Medicaid Eligibility Policy Manual, chapter 5101:1-37 will be located within Chapter 7000 of the Public Assistance Manual.

The managed care rules in PAM Chapter 2000 are being updated with the most current effective date.

5101:1-37-01 Medicaid: introduction and definition of program.

Former rules 5101:1-39-01 and 5101:1-39-37 are being rescinded and replaced with new rule 5101:1-37-01. This rule will obsolete PAM Sections 7100, 7101, 7102, and 7200. The covered services under Medicaid can be found in the Ohio Medicaid Provider handbook.


Rule 5101:1-3-29 is being revised to remove references to the Medicaid program for individuals convicted of fraudulently misrepresenting their residence. This new rule is specific to all categories of Medicaid. Rule 5101:1-3-29 is located in the Cash Assistance Manual.


This new rule contains language specific to Medicaid which was formerly contained in rule 5101:1-1-14. Rule 5101:1-1-14 is being amended to remove references to Medicaid and is located in the Cash Assistance Manual.

The significant differences in this new Medicaid stand-alone rule from the Medicaid requirements that had previously been in rule 5101:1-1-14 are: inclusion of Medicaid specific language, inclusion of language in paragraph (C)(2) reflecting federal law prohibiting counties from terminating Medicaid when a family moves from one county to another and requiring a reapplication in the new county of residence; clarification in
paragraph (E) of CDJFS responsibilities in conducting pretermination reviews; and clarification in paragraph (I) of CDJFS responsibilities for Medicaid in situations that involve multiple counties.


This new rule contains language specific to Medicaid which was formerly contained in rule 5101:1-1-50 Citizenship: Required Written Declaration of Citizenship/Alien Status and the Use of the Systematic Alien Verification for Entitlements (SAVE) Program; rule 5101:1-1-50 has been amended to remove references to Medicaid and is located in the Cash Assistance Manual.

The significant changes in this rule from the requirements that had previously been in rule 5101:1-1-50 are: the inclusion of Medicaid specific language; clarification in paragraph (B) that an individual who is otherwise a required assistance group member who claims to be of an ineligible alien status does not have to verify his status with the INS; clarification in paragraph (C) that no eligibility determination will be delayed solely because of the alien status verification index (ASVI) database or the INS office has failed to verify alien registration status. Rule 5101:1-1-50 is located in the Cash Assistance Manual.


This new rule contains language specific to Medicaid which was formerly contained in rule 5101:1-1-36. Rule 5101:1-1-36 has been amended to remove references to Medicaid and is located in the Cash Assistance Manual.

The significant difference in this new Medicaid stand-alone rule from the Medicaid requirements that had previously been in rule 5101:1-1-36 is the inclusion of Medicaid specific language.


This new rule contains language specific to Medicaid which was formerly contained in rule 5101:1-2-55 -OWF, DA, RSS, RRP: delayed cash assistance payments and replacement warrants. Rule 5101:1-2-55 has been amended to remove references to Medicaid and is located in the Cash Assistance Manual.

The significant change in this rule from the requirements that had previously been in rule 5101:1-2-55 is the inclusion of Medicaid specific language.


No changes to this rule.


No changes to this rule.

5101:1-38-01.2 Medicaid and covered families and children Medicaid: The application process.

No changes to this rule.

5101:1-38-01.3 Medicaid and covered families and children Medicaid (CFC): retroactive coverage

Former rules 5101:1-39-02 and 5101:1-40-09.2 are being rescinded. New rule 5101:1-38-01.3 has been written to include all categories of Medicaid when exploring retroactive Medicaid assistance. The only significant change is that for individuals who have died, but prior to their death, filed an application for Medicaid and appointed an authorized representative, the authorized representative may continue to represent the individual through the application process. This rule obsoletes PAM Sections 7103 and subsections and 11717 and subsections.

5101:1-38-01.4 Data systems and Medicaid health care coverage.

The data systems and Medicaid health care coverage dates have been included in the Public Assistance Manual in Sections 7104 and subsections and in 11718 and subsections but had not been rule-filed. This new rule will obsolete these PAM Sections.
5101:1-38-02 Medicaid and covered families and children (CFC): Verification and reporting requirements.
No changes to this rule.

No changes to this rule.

This new rule rescinds former rules 5101:1-39-63 and 5101:1-39-64. This new rule clarifies that buy-in is the Medicaid benefit that pays an individual's Medicare Part B premium, which Medicaid eligible individuals are eligible for buy-in, the effective date of the buy-in and when buy-in eligibility ends. This rule obsoletes PAM Sections 2110 through 2120.1 and the Buy-in Master Code Explanations in the Appendix in PAM Chapter 2000. The buy-in manual is on-line. The Part A transaction codes can be found in Section VII and the Part B transaction codes can be found in Section V of the on-line buy-in manual.

5101:1-38-04 Outstationing of eligibility workers at disproportionate share hospitals and federally qualified health centers.
No changes to this rule.

5101:1-38-05 Early and periodic screening, diagnosis and treatment (EPSDT) - "Healthchek".
No changes to this rule.

5101:1-38-06 Pregnancy-related services.
No changes to this rule.

5101:1-38-10 Medicaid estate recovery.
No changes to this rule.

5101:1-38-20 Medicaid and covered families and children: overpayments
This new rule rescinds former rules 5101:1-39-66, 5101:1-39-66.1, 5101:1-39-67, 5101:1-39-67.1. The significant changes in this rule are as follows: The rule clarifies that if a member of the assistance group would have been eligible for another category of Medicaid, then the full amount of the claim for that member of the assistance group may not be recoverable; clarifies the overpayment period; adds information that for overpayments that occur as the result of an improper transfer of resources the overpayment period begins with the month of the transfer and continues until the period of restricted coverage has expired. This rule obsoletes Public Assistance Letter No. 817.

This rule rescinds former rules 5101:1-39-53.1 and 5101:1-39-53.4. This new rule consolidates the eligibility requirements for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and the Qualified Individuals-2 (QI-2) categories of Medicaid. There are no changes to the eligibility requirements. This rule obsoletes PAM Sections 7202 through 7202.10 and 7212 through 7212.5.

This new rule rescinds former rule 5101:1-39-53.3. There are no changes to the eligibility requirements for the QWDI program.

5101:1-39-02 Medicaid: Grandfathering provisions resulting from the implementation of the Supplemental Security Income (SSI) program.
This new rule rescinds former rule 5101:1-39-47. There are no changes to this rule. This rule obsoletes PAM Section 7206.

5101:1-39-02.1 Medicaid: treatment of social security payments made to certain persons who are made ineligible for SSI due to such payments.
This new rule rescinds former rule 5101:1-39-38. Clarification is being provided that only the Social Security payments are disregarded when determining Medicaid eligibility. Any other income must still be considered.
The disregard of the Social Security payment does not apply to individuals who are in a long term care facility or enrolled in a home and community-based services waiver. This rule obsoletes PAM Sections 7208 through 7209.

5101:1-39-02.2 Medicaid: aged, blind or disabled philanthropic long term care facility medicaid assistance groups.

This new rule rescinds former rule 5101:1-39-46. There are no changes to this rule. This rule obsoletes PAM Section 7203.5.


This new rule replaces former rule 5101:1-39-41. This rule clarifies that an individual who is eligible for Medicaid under the 1619 provisions shall not have a spenddown liability nor shall a couple if one member of the couple is eligible under 1619. This rule obsoletes PAM Section 7203.6 through 7203.62.


The only significant change in this rule is the addition of (D)(3)(b) that redefines disability for an individual under age 18 to state that to be considered disabled under SSI the child must have a medically determinable physical or mental impairment which results in marked and severe functional limitations and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve months and no individual under the age of eighteen who engages in substantial gainful activity may be considered disabled.

5101:1-39-03.1 Medicaid: county department of job and family services (CDJFS) determination.

This rule clarifies that for presumptive disability approvals by the CDJFS, a medical information packet must still be developed and submitted to CMS. In addition, language changes have been made relating to presumptive disability determinations for individuals who have a developmental disability. Additional information on presumptive disability is provided relating to children age 6 months or less who have a low birth weight corresponding to their gestational age. AIDS, in and of itself, is no longer a presumptive disability. Presumptive disability exists when a physician or knowledgeable hospice official confirms an individual is receiving hospice services because of terminal cancer. In addition, presumptive disability exists for an individual with the inability to ambulate without the use of a walker or bilateral handheld assistive devise more than 2 weeks following a spinal cord injury with confirmation of such status from an appropriate medical professional.

5101:1-39-03.2 County medical services section (CMS) referrals.

There are no significant changes to this rule other than the addition of the Code of Federal Regulations cite relating to the determination of disability by CMS.

5101:1-39-03.3 Continuation of medicaid coverage.

There are no significant changes to this rule.

5101:1-39-03.4 Medicaid: continued medicaid coverage for children who lost their eligibility for supplemental security income (SSI) due to a change in the disability determination.

This is a new rule relating to the continued Medicaid coverage for children who lost their SSI eligibility due to a change in the disability determination.

Section 4913 of the BBA provided that children who were receiving SSI payments and Medicaid on August 22, 1996 and who, due to the passage of the new definition of disability for children, were no longer eligible for SSI, to remain categorically eligible for Medicaid as a disabled child under the SSI disability criteria that was in effect for children prior to August 22, 1996.

These children are protected up to age 18. Any time a disability determination is to be completed, CMS is required to use the pre August 22, 1996 child's disability criteria. Protected children are still required to meet the Medicaid income and resource requirements of whichever Medicaid category they had been approved for in order to keep Medicaid coverage.
In Ohio, approximately 1250 children were identified as being in receipt of SSI and Medicaid as of August 22, 1996. These children are identified on CRIS-E screen AEISD.

No changes to this rule. This rule obsoletes PAM Sections 7404 through 7404.10.

5101:1-39-05 Medicaid: resource requirement
This new rule rescinds former rule 5101:1-39-05. The significant changes include the following: a definition of assets relating to the receipt of income has been added and includes both income and resources that the individual is entitled to but does not receive; removed the definitions of types of ownership interest; adds a definition of equitable ownership; removed reference to liquid and non-liquid resources; provides that a resource is available regardless of whether the individual is competent; couples separated by institutionalization on or prior to December 31, 1989 but the institutionalized individual returned to a community setting on or after January 1, 1990 for thirty days or longer and then again becomes institutionalized shall have resources assessed in accordance with rules 5101:1-39-35 through 5101:1-39-36.5. Obsoletes PAM Sections 7412 through 7412.24.

5101:1-39-06 Medicaid: social security administration reporting alleged transfer of resources by supplemental security income (SSI) applicants to the Ohio department of job and family services (ODJFS)
This rule is being submitted for rule review. The significant changes are the removal of the CDJFS's requirement to report information back to the local SSA branch and to include information that if the individual is subject to a period of restricted coverage as delineated in rule 5101:1-39-07.7 of the Administrative Code that the appropriate notice will be issued. This rule obsoletes PAM Section 7412.8.

5101:1-39-07 Medicaid: transfer of resources
This new rule rescinds former rules 5101:1-39-07, 5101:1-39-07.1, 5101:1-39-07.2, 5101:1-39-07.3, 5101:1-39-07.4, 5101:1-39-07.5, 5101:1-39-07.6, 5101:1-39-07.7, 5101:1-39-07.8 and 5101:1-39-07.9. The significant changes in this rule as a result of the consolidation of the former rules are the following: a definitions section has been added; clarification that a transfer of a legal or equitable interest in a resource for less than fair market value may be an improper transfer; clarifies that the transfer of an "exempt" home may be improper; clarification that resources may be transferred to a trust for the sole benefit of an individual's disabled child; clarification on the transfer for the sole benefit provision; clarification that any amount of a couple's resources that exceed the community spouse resource allowance must be utilized for the support and medical care of the institutionalized spouse unless specifically permitted under another rule; any amount that exceeds the community spouse's resource allowance cannot be transferred to the community spouse unless specifically permitted under another rule; any amount that exceeds the community spouse's resource allowance cannot be converted to another form for the purpose of generating additional income for the community spouse unless specifically permitted under another rule; a transfer of real property is established on the date it is recorded with the county auditor or other appropriated government agency; to qualify for a waiver of a period of restricted medicaid coverage due to an undue hardship the individual must document that they have attempted a civil action to compel the return of the resources or that their health and safety will be materially endangered.

This rule obsoletes PAM Sections 7412.5 through 7412.63 and ACT No. 141.

5101:1-39-07.1 Medicaid: disposal of resources for Ohio department of mental retardation and development disability and/or Ohio department of mental health assistance groups
This new rule rescinds former rule 5101:1-39-07.6. There are no significant changes to this rule. This rule obsoletes PAM Sections 7412.7 through 7412.83.

5101:1-39-08 Medicaid: income
This rule is being submitted for rule review. The significant changes are the clarification that child support and/or spousal support are not allowable deductions from income and that child support arrearages paid to the Medicaid-eligible parent for a child is not considered income to the parent. This rule obsoletes PAM Sections 7430 through 7430.9.

This rule is being rescinded. Reference rule 5101:1-38-02 for information on verifications. This obsoletes PAM Sections 7405 and 7405.1

5101:1-39-10 Medicaid: eligibility through the spenddown process.

This rule sets forth the spenddown process for the Medicaid program for the aged, blind, or disabled (ABD). An individual who is subject to the spenddown process is referred to as a "spenddown assistance group (SAG)". Definitions have been added. A reference to exceptions to spenddown are identified within the rule. Additional information has been added to identify allowable deductions in the spenddown budget for the SAG. Clarification has been added about the definition of "family member". Information on allowable transportation expenses has been added. Clarification has been added regarding the use of long term care costs in situations where the individual is subject to a period of restricted coverage due to an improper transfer of assets.

Further information on the pay-in method of meeting spenddown is included. In addition, at the county's option, the rule also now permits the SAG to combine a current incurred medical expense and the pay-in method in the same month to meet his or her spenddown liability.

A methodology has also been added to provide instructions to the CDJFS if a medical expense is submitted for use toward meeting the spenddown and the CDJFS questions the expense.

Clarification has also been added regarding the amount of time the CDJFS has to release the Medicaid card once the spenddown liability has been met.

Information has also been added that requires the CDJFS to provide hearing rights if the use of a medical expense or service is being denied because the CDJFS has determined that the medical expense or service is not an allowable deduction for spenddown purposes.

This rule obsoletes PAM Sections 7467 through 7467.7.


This rule is being rescinded and has been incorporated into rule 5101:1-39-10.


This rule is being rescinded and has been incorporated into rule 5101:1-39-10.


This rule is being rescinded and has been incorporated into rule 5101:1-39-10.

5101:1-39-11 Medicaid eligibility for persons living in state institutions for the mentally ill and mentally retarded.

This rule is being submitted for rule review. There are no significant changes. This rule will obsolete PAM Section 7401.7.


This rule is being submitted for rule review. There are no significant changes. This rule will obsolete PAM Sections 7538 and 7543 and subsections.

5101:1-39-12.1 Billing process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

This rule was submitted for rule review. References within the body of the rule have been updated. This is new information that had previously been introduced in Medical Assistance Letter 96-1.


This rule is being added to Chapter 7000.


This rule was submitted for rule review. References within the body of the rule have been updated. This rule obsoletes PAM Section 7437.
Medicaid: treatment of earned income.
There are no significant changes. This rule obsoletes PAM sections 7432 through 7432.5

There are no significant changes. This rule obsoletes PAM Section 7432.6.

There are no significant changes. This rule obsoletes PAM Section 7433.

5101:1-39-15.3 Treatment of income received from participation in programs established under the National and Community Service Trust Act of 1993.
There are no significant changes. This rule obsoletes PAM Section 7434.

There are no significant changes. This rule obsoletes PAM Sections 7436 and 7436.1.

5101:1-39-17 Medicaid: In-kind support and maintenance.
No changes to this rule.

No changes to this rule.

There are no significant changes. This rule obsoletes PAM Sections 7448 through 7453.

There are no significant changes. This rule obsoletes PAM Sections 7457 and subsections.

There are no significant changes. This rule obsoletes PAM Section 7457.3.

There are no significant changes. This rule obsoletes PAM Section 7457.4.

No changes to this rule.

This rule is being submitted for rule review. The only significant change is the addition of language that states that a continuous period of institutionalization is also established if the individual dies prior to the thirtieth consecutive day when it is determined that the individual would have likely continued to remain institutionalized or in receipt of HCBS waiver services. This rule obsoletes PAM Sections 7520 through 7525.

This rule is being submitted for rule review. The following are the only significant changes: The family allowance for each family member is equal to one third of the MMMNA less the gross amount of the monthly income of that family member and rounded down and to remove the provision that in any month in which the MIA and FA was used as a deduction in the patient liability, the family who applies for OWF is ineligible for retroactive Medicaid. This rule obsoletes a portion of PAM Section 7501 and PAM Sections 7526 through 7534.

This rule is being submitted for rule review. The only significant changes are to specifically state that child support and spousal support are not allowable deductions and to remove the redundancy relating to the allowable deductions in the patient liability budget. This rule obsoletes PAM Sections 7540 through 7542.

There are no changes in the rule.

5101:1-39-22.4 Medicaid: family allowance for dependents of institutionalized individuals and home and community-based services waiver (HCBS) individuals who do not have a community spouse.

The only significant change is the removal of the language that prohibits an individual who received a family maintenance needs allowance in a month from being eligible for Medicaid under the LIF category of Medicaid. This rule obsoletes ACT No. 188.


The only significant change is to remove language relating to a temporary institutionalization that occurred prior to July 1, 1988. This rule obsoletes PAM Sections 7106 and 7542.8.


No changes to this rule.


This new rule rescinds former rule 5101:1-39-22.8. This new rule governs the treatment of annuities in all eligibility determinations for all categories of Medicaid. Definitions related to annuities have been added. Annuities must be purchased from entities that are engaged in the business of the sale of commercial annuities to the public. Assets used in exchange for a private annuity are presumed to be improperly transferred. Annuity payments must be based on the life expectancy of the annuitant. Resources that exceed the community spouse’s resource allowance cannot be used to purchase an annuity for the community spouse unless permitted under rules 5101:1-39-36.1 or 5101:1-6-7-02. Otherwise, such resources that are transferred must be reviewed under the transfer of assets rule. If an annuity has a balloon payment provision, the applicant must produce clear and convincing medical evidence that the annuitant is expected to actually live past the date of the balloon payment.


No changes to this rule.


No changes to this rule.


This new rule rescinds former rule 5101:1-39-27.1. This new rule governs the treatment of trusts for all categories of Medicaid and sets out five categories of trusts as well as definitions related to trusts. The five categories are as follows: (1) Self-settled trusts established before August 11, 1993 also referred to as "Medicaid Qualifying Trusts"; (2) Self-settled trust established on or after August 11, 1993. (3) Exempt trusts. There has been a significant change in the Supplemental Services Trust. As a result of changes in Section 1339.51 of the Ohio Revised Code, this type of trust no longer needs to be a testamentary trust. (4) Trusts established by someone else for the benefit of the applicant/recipient. This type of trust is established and funded by someone other than the applicant/recipient and the applicant/recipient never held an ownership interest in the assets or property prior to the establishment of the trust. This type of trust will be considered an available resource if the trust permits the trustee to expend principal or corpus or assets of the trust for the applicant/recipient’s medical care, or care, or comfort, or maintenance, or health or welfare, or general well-being, or a combination of these purposes. The trust will be considered an available resource even if the trust contains a provision that prohibits the trustee from making payments that would supplant or replace Medicaid, public assistance, or government assistance, prohibits the trustee from making payments which would impact the applicant/recipient’s right or ability or opportunity to receive Medicaid, public assistance, or government assistance, attempts to prevent the trust or its corpus or principal from being counted as an available resource under this rule. This type of trust shall not be counted as an available resource if the trust contains a clear statement requiring the trustee to preserve a portion of the trust for another beneficiary, or a clear statement requiring the trustee to use a portion of the trust for a purpose other than the medical care, etc. of the applicant/recipient, or the trustee is limited to making fixed periodic payments, or if there is a clear statement...
requiring the trustee to terminate the trust if it is counted as an available resource, or if there is a final judgment from a court expressly prohibiting the trustee from using part or all of the trust for the applicant/recipient, or the applicant/recipient presents a final judgment demonstrating that they were unsuccessful in a civil action against the trustee. (5) Trusts established by will for the benefit of a surviving spouse. This is a trust established by the will of the deceased spouse. If there are any circumstances under which payment from the trust could be made to or for the benefit of the surviving spouse, that portion shall be considered an available resource.

This new rule supercedes all previous rules governing trusts and the CDJFS shall apply it prospectively to all determinations and redeterminations of eligibility for all applicants and recipients. Any determination or redetermination made in accordance with this rule shall not be affected by or governed by any prior eligibility determinations made under former rules governing trusts.

There are no significant changes to this rule. This rule obsoletes PAM Sections 7413.2 and 7413.3.

The significant changes to this rule are as follows: The value of a promissory note and/or mortgage is its outstanding balance; if the terms of the promissory note or mortgage prohibit the sale of the note then the assets given in exchange for the note will be deemed improperly transferred in accordance with the provisions in rule 5101:1-39-07; if the note is sold for an amount less than the value of assets given in exchange for the note, the difference will be deemed improperly transferred as of the date of the sale of the note or mortgage. This rule obsoletes PAM Sections 7413.4 through 7413.9.

This rule is being revised to change the language "prepaid burial contracts" to "preneed funeral contracts" to more accurately reflect the definition that is found in Revised Code section 1111.19. The revisions include additional references to life insurance funded preneed funeral contracts and burial spaces administrative code rules. This rule obsoletes PAM Section 7413.12.

The significant changes to this rule are as follows: The transfer of a lump-sum, income or resource, in the month of receipt, is subject to review under the transfer of asset provisions of rule 5101:1-39-07; clarification that retroactive payments from SSI or RSDI is unearned income in the month of receipt; home and community-based services recipients are treated the same as nursing home recipients who have received a lump-sum; clarification that the recipient is not limited to repaying the ODJFS for only the past cost of nursing home care. Child support payment distributions made by ODJFS pursuant to division (C) of Section 1 of Am. S.B. 170 of the 124th General Assembly and rules 5101:1-29-31.1 and 5101:1-29-31.2 of the Administrative Code are exempt as income in the month of receipt and as a resource in the month following the month of receipt and for all months thereafter. This rule obsoletes PAM Section 7413.10.

There are no changes to this rule. This rule obsoletes PAM Section 7413.11.

5101:1-39-28Household goods and personal effects as resources.
There are no significant changes. This rule obsoletes PAM Section 7414.

5101:1-39-29Automobiles and other modes of transportation as resources.
There are no significant changes. This rule obsoletes PAM Sections 7415.1 through 7415.4.

This rule is being revised to provide more information on the determination of the ownership and value of life insurance policies. These changes include additional definitions pertinent to life insurance, the treatment of accelerated life insurance payments, and life insurance funded preneed funeral contracts. There are several significant changes in the determination of Medicaid eligibility when an individual changes ownership of a life insurance policy to a funeral provider to fund a preneed funeral contract. These changes are as follows:
1) A preneed funeral contract that is funded by a life insurance policy can stipulate within the contract that goods and services will be provided commensurate with the amount of insurance proceeds that are available at the time the services are required.

2) The preneed funeral contract must contain a provision that any funds in excess of the costs will be paid to the deceased individual's estate.

3) Ownership of the life insurance policy must be changed to the funeral provider.

4) If the cash surrender value of the policy(ies) affects the individual's eligibility for Medicaid, and the individual irrevocably changes ownership of the policy(ies) to the funeral provider and obtains an irrevocable preneed funeral contract, the effective date of the transfer will be considered the date that the irrevocable change of ownership was signed by both the owner of the policy(ies) and the funeral provider, whichever occurs last. However, verification must be received by the CDJFS that the change of ownership has been acknowledged and completed by the insurer before the eligibility determiner can complete the determination of eligibility.

This rule obsoletes PAM Sections 7416.1 through 7416.6

This rule is being rescinded and replaced with rule 5101:1-39-30. This rule obsoletes PAM Section 7416.7.

There are no significant changes to this rule. This rule obsoletes PAM Sections 7417 through 7417.1.

This new rule rescinds former rule 5101:1-39-31.2. The only significant change is that the rule has been reformatted. This rule obsoletes PAM Section 7417.2.

This new rule rescinds former rule 5101:1-39-31.3. The significant changes in this rule are the following: the individual must provide verification that the property was listed for sale with a real estate agent or firm on or before the date that the property ceased to meet an exemption; the proceeds from the sale of the property must be used for the care and support of the Medicaid recipient; if the property is not sold within the six months after its initial listing, the total equity value of the property will be counted as a resource unless the individual demonstrates that it qualifies as property that cannot be sold as set forth in rule 5101:1-39-05 of the Administrative Code. This rule obsoletes PAM Section 7417.3.

The only significant change is that the home replacement period begins on the date that the proceeds of the sale are received by the individual. This rule obsoletes PAM Section 7417.4.

5101:1-39-32 Life estates and life leases as resources.
This new rule rescinds former rule 5101:1-39-32. The significant changes to this rule are as follows: A life estate that is established within the look-back period with the applicant/recipient's own property and in which he or she does not have the right to use the property or sell the life estate is presumed improperly transferred; a life estate is established on the date it is recorded with the county auditor or other appropriate government agency if the life estate is recorded within six months of the signature date. The CDJFS shall disregard any life estate that is not properly recorded and shall consider the entire property as an available resource to the applicant/recipient. This rule obsoletes PAM Section 7418 through 7418.2.

This new rule rescinds former rule 5101:1-39-32.1. The significant changes in this rule are the following: Land contracts are no longer identified separately from other types of property agreements; negotiable agreements are defined and a copy of the property agreement must be recorded with the county auditor or county recorder, or other appropriate government agency charged with the responsibility of recording property agreements; a property agreement is established on the date it is recorded if the property agreement is recorded within six months of the date of signature. Any property agreement that is not recorded is
disregarded and the property is considered an available resource. The fair market value of the property agreement at the time of the transfer must be equal to the fair market value of the property given by the individual in exchange for the property agreement; the assets given in exchange for a non-negotiable agreement will be deemed improperly transferred. This rule obsoletes PAM Section 7418.3.

This rule has no changes. This rule obsoletes PAM Section 7413.13.

5101:1-39-33 Real or personal property essential to self-support.
This new rule rescinds former rule 5101:1-39-33. The significant changes to this rule are as follows: basic daily living needs is defined as any food, basic clothing, basic shelter and any medical care that are not provided by Medicaid; up to six thousand dollars of income producing property may be exempt from being counted as a resource if the income received by the applicant/recipient is equal to or greater than six percent of the equity; property that represents the authority granted by a government agency to engage in an income producing activity. This category includes any permit, license, or a similar instrument issued by a federal, state, or local government agency; property that produces goods or services and the income is used for the sole purpose of providing for their own basic daily living needs; property that produces goods or services may be exempt up to six thousand dollars of its equity value if the property provides either a product or services that supplies basic daily living needs for the applicant/recipient; if there is more than one potentially excludable property, the six percent return requirement applies individually to each property and the six thousand dollars equity value limit applies to the total equity value of all the properties meeting the six percent return requirement. This rule obsoletes PAM Section 7419 through 7419.2.

5101:1-39-34 Deeming of resources.
No changes to this rule.

No changes to this rule.

No changes to this rule.

The excess resources (i.e., institutionalized spouse's share) are to be used for the benefit of the institutionalized spouse, legal obligations of either spouse or for the purchase and maintenance of exempt resources as delineated in rule 5101:1-39-35. The community spouse must sign and return the form indicating whether he or she will cooperate in making the excess resources available to the IS. Failure to sign and return the form will cause the IS to be ineligible for Medicaid due to excess resources. In unusual situations a resource assessment cannot be completed due to the non-cooperation of the CS. In order to determine eligibility for the IS, the IS must take any and all appropriate legal action to complete the production of necessary verifications. Undue hardship does not exist when the IS transfers his or her resources to the CS and then the CS refuses to cooperate.

5101:1-39-36.2 Medicaid: transfer of resources for institutionalized spouses with a spouse in the community.
This rule rescinds former rules 5101:1-39-36.3, 5101:1-39-36.4 and 5101:1-39-36.5. The information formerly contained in those rules has been added to this rule. This rule states that if the institutionalized spouse (IS) fails to transfer resources within the protected period of eligibility, the resources must be considered available to the institutionalized spouse at the time of the redetermination of eligibility. This rule also adds the information on the allocation of the resources when determining retroactive coverage. Resources that the IS intends to transfer to the community spouse (CS) are considered available to the CS during the protected eligibility period. This rule rescinds PAM sections 7515.3 and 7515.4 through 7515.6
5101:1-39-53.5 Direct reimbursement of medicare premiums and/or coinsurance and deductibles to individuals eligible for qualified medicare beneficiary (QMB) or specified low-income medicare beneficiary (SLMB) medicaid.

There are no significant changes in the content of this rule.


No changes to this rule.


No changes to this rule.


No changes to this rule.


This rule is being submitted for rule review. There are no significant changes in the content of this rule.

5101:1-39-85 Medicaid-eligible veterans and surviving spouses of certain veterans in long term care facilities with no community spouse and dependent family member(s).

This rule is being submitted for rule review. There are no significant changes in the content of the rule


This rule has been amended to remove information on HCBS waivers that are no longer in existence. Information has been added about the residential facility waiver that was implemented effective July 1, 1997 and the ODJFS-administered waiver (Ohio home care waiver) that was effective July 1, 1998.


No changes to this rule.


No changes to this rule.

CHAPTER 6000
The rules relating to the Residential State Supplement program have been amended and consolidated from seventeen rules to seven rules.

5101:1-17-01 The residential state supplement program.

This rule has been revised to remove the historical references to the implementation of the RSS program.

5101:1-17-02 RSS eligibility requirements.

Rules 5101:1-17-02 and 5101:1-17-16 are being rescinded and consolidated into new rule 5101:1-17-02. The significant changes in this new rule are the prohibition against RSS eligibility for an individual who is enrolled in a home and community-based waiver, PACE, or enrolled in a Medicare or Medicaid-certified hospice program. In addition, an individual who is currently eligible for Medicaid is no longer required to complete a JFS 07100 or JFS 07200 or a face-to-face interview.

5101:1-17-03 RSS registration and enrollment process.

Rules 5101:1-17-03, 5101:1-17-05, 5101:1-17-06 and 5101:1-17-07 are being rescinded and consolidated into new rule 5101:1-17-03. The definitions of appropriate living arrangements have been revised to mirror the definitions in Department of Aging’s rule 173-35-02 relating to the RSS program since RSS administers the RSS program. No other significant changes have been made.

5101:1-17-04 Medicaid and RSS financial eligibility determinations for the RSS applicant.

Rules 5101:1-17-04, 5101:1-17-09 and 5101:1-17-10 are being rescinded and consolidated into new rule 5101:1-17-04. The only significant change is to clarify that both impairment-related and blind work expenses are allowable deductions from earned income.
5101:1-17-05 Determination of RSS payment.

Rules 5101:1-17-11, 5101:1-17-12, 5101:1-17-14 and 5101:1-17-15 are being rescinded and consolidated into new rule 5101:1-17-05. There are no significant changes.

5101:1-17-06 RSS financial need standards and allowable fees.

Rule 5101:1-17-08 is being rescinded and replaced with new rule 5101:1-17-06. The significant change in this rule is the increase in the allowable fee for the various RSS living arrangements that was effective July 1, 2000. The allowable living arrangement fee was increased across the board by $50 for an individual and $100 for a couple. CRIS-E table TOSS was increased effective July 1, 2000.

5101:1-17-07 Pass-along of SSI income cost-of-living adjustments (COLA) for RSS.

Rule 5101:1-17-13 is being rescinded and replaced with new rule 5101:1-17-07. This rule includes the 2001 total SSI disregard to date for SSI recipients who are in receipt of RSS payments.

The ODHS 7120 has been revised to reflect the change from the Optional State Supplement to the Residential State Supplement.

The ODA 1031 "Residential State Supplement (RSS) Documentation of Eligibility" form is being obsoleted.

INSTRUCTIONS:

Remove and file as obsolete from Chapter 1000 the Outline of Contents and replace with the attached Outline of Contents dated November 1, 2002.


Remove and file as obsolete the Outline of Contents for Chapter 2000 and replace with the attached corresponding page dated November 1, 2002.

Remove and file as obsolete PAM Sections 2110. through 2199.

Remove and file as obsolete managed care rules 5101:3-26-01, 5101:3-26-02, and 5101:3-26-02.1 dated September 27, 1997 and replace with the attached rules 5101:3-26-01, 5101:3-26-02, and 5101:3-26-02.1 dated July 1, 2002.

Remove and file as obsolete from the Appendix to Chapter 2000 the Buy-in Master List Code Explanation.

Remove and file as obsolete from the Appendix to Chapter 2000 the JFS 06612 "Health Insurance Information Form and the JFS 06613 "Accident/Injury Insurance Information Form.


Remove and file as obsolete from PAM Chapter 6000 the Outline of Contents and rules 5101:1-17-01 through 5101:1-17-16 and replace with the attached corresponding Outline of Contents and rules 5101:1-17-01 through 5101:1-17-07 dated November 1, 2002.

Remove the ODHS 7120 "Optional State Supplement Referral" form and replace with the attached corresponding JFS 07120 "Residential State Supplement Referral" form dated 03/2002.

Remove and file as obsolete the ODA 1031 "Residential State Supplement (RSS) Documentation of Eligibility.


Add to the Appendix to Chapter 7000 immediately following the Evaluacion Para Healthchek y Servicios Para Mujeres Encinta JFS 03531 the JFS 06612 Health Insurance Information Sheet and the JFS 06613 Accident/Injury Insurance Information Form.

Remove and file as obsolete the following Action Change Transmittal Letters:
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Obsolete all ABD Medicaid and CFC Medicaid (ADC-Related) District Director clarification letters that were issued prior to October 1, 2002.
Public Assistance Manual Transmittal Letter No. 432

September 17, 2002

To: All Public Assistance Manual Holders
From: Thomas J. Hayes, Director
Subject: Breast and Cervical Cancer Project (BCCP) Medicaid

The rules in this Manual Transmittal Letter (MTL) reflect the establishment of a new category of medicaid on July 1, 2002. These rules set forth the details of Ohio's implementation of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) (Public Law 106-354), which authorized an optional category of medicaid to provide full medicaid benefits to certain individuals who need treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. Ohio HB94 gave statutory authority for Ohio to implement this optional category of medicaid. These rules reflect a coordinated effort of both Ohio Department of Job and Family Services (ODJFS) and Ohio Department of Health (ODH).

Because eligibility in this new category of Medicaid is limited to certain women diagnosed with breast or cervical cancer through ODH's Breast and Cervical Cancer Project (BCCP), this category of Medicaid is administered at ODJFS, in coordination with ODH and its BCCP regional subgrantees. BCCP Medicaid applications are available only through ODH BCCP regional subgrantees.

Although BCCP Medicaid is administered at ODJFS, some cases may require coordination of effort between ODJFS and CDJFS staff. For example, some cases may require the CDJFS to determine if a BCCP Medicaid applicant is eligible for another category of Medicaid. CDJFS staff should reference CRIS-E View Flash Bulletin Dated 072502 titled "New Medicaid Category: BCCP Medicaid" for additional information regarding this category of Medicaid.

CHAPTER 7000

This new rule delineates the federal goals and provides statutory background for this new category of medicaid.

This new rule provides definitions for terms used with this new category of medicaid.

This new rule outlines the eligibility requirements for this new category of medicaid.

This new rule outlines the beginning and end dates of eligibility for this new category of medicaid.

This new rule outlines the application and eligibility determination process for this new category of medicaid and delineates the responsibilities of the staff of ODJFS and the designated local agencies or subgrantees of the Ohio Department of Health.

INSTRUCTIONS
Remove the last three pages of the Table of Contents for PAM Chapter 7000, which are dated July 1, 2000, have the footer "MTL NO. 417," and begin with "7542.6 Past Medical Expenses, " "APPENDIX Application for Help With Your Medicare Expenses ODHS 7103," and "APPENDIX Notice of Requirement to Transfer Extra Resources ODHS 7106." Insert replacement Table of Content pages for PAM Chapter 7000, indicated with the footer "MTL NO. 432."

Insert new rules 5101:1-41-01 through 5101:1-41-05 immediately after PAM Section 7550.2.
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: THOMAS J. HAYES, DIRECTOR
SUBJECT: Covered Families and Children Medicaid: Assistance Group Construction, Covered Groups and Living Arrangements, Children Receiving State Adoption Assistance Subsidies, Allocating Income from Non-Assistance Group Members

This MTL transmits changes with the proposed effective date of June 1, 2002. If there are any changes made to any of the rules contained in this MTL during the JCARR review period, corrected rules will be sent out with a subsequent MTL.

The rules contained in this MTL reflect changes and expanded language regarding formation of assistance groups for Covered Families and Children (CFC) Medicaid. The determination of financial eligibility is in part determined by assessing if an individual for whom eligibility is being explored lives with a parent or spouse. This transmittal provides a framework for completing this determination as well as to provide a definition of "temporary absence" applicable to CFC Medicaid. This transmittal also clarifies the federal prohibitions against the deeming of income from certain individuals; i.e., it expands upon the provisions which had formerly been limited to income earmarked by court order or law.

Modifications to the provisions of the eligibility determination process for children who are receiving state adoption assistance subsidies have been made. There is a new income allocation rule which replaces the separate rules for CFC minor caretaker, stepparent, and other rules for allocating income from certain non-assistance group members.

Also contained in this transmittal are other clarifications that more accurately reflect federal Medicaid law and rule. This transmittal will obsolete some Public Assistance Manual (PAM) sections in Chapter 11,000 which are not in Ohio Administrative Code format. PAM sections concerning conditional eligibility for assistance groups who own non-exempt real property are being obsoleted because this provision no longer exist.

The changes in this MTL are being coordinated with CRIS-E and CRIS-E procedures will be addressed in a CLVB.

CHAPTER 11000

5101:1-40-01: Covered Families and Children Medicaid: Assistance Groups and Definitions
This rule has been rewritten to better support the delinking of CFC Medicaid from OWF Medicaid. An expanded definition of an assistance group is included and fully incorporates the federal Medicaid prohibitions against deeming income of certain individuals (e.g., siblings to siblings). The former earmarking provision that limited non-deeming to income earmarked by court order or law is more restrictive than permitted under federal Medicaid provisions. The definition of specified relative is now included in this rule to further add clarity to the assistance grouping principles. Rule 5101:1-40-207 is being rescinded to support the redefinition of situations where deeming of income is prohibited.

5101:1-40-01.1: Covered Families and Children Medicaid: Covered Groups
This rule has been rewritten to more accurately describe the various covered families and children groups for Ohio. This helps to clarify that OWF recipients receive Medicaid under the Healthy Families/LIF covered group.

5101:1-40-02: Covered Families and Children: OWF Recipients Eligible for Medicaid
Has also been amended to delete the reference that participants in a subsidized employment program are automatically eligible for Medicaid.

5101:1-40-03: Covered Families and Children Medicaid: Children in Care
The former rules concerning children in care who receive a state adoption assistance subsidy and those whose state adoption subsidy is based upon a determination that the child has special medical or rehabilitative need are being merged into a single rule. The primary difference between these two adoption subsidy arrangements is the treatment of the income of the adoptive parent(s). State adoption subsidies are based upon a determination of special medical or rehabilitative needs, neither the income of the adoptive parent(s) nor the subsidy payments for the child are counted toward the Medicaid eligibility for the child. As long as the special needs subsidy payment continues, the child is considered as a household size of one and only the child's income is counted. If the state adoption subsidy is not based upon a determination of special medical or rehabilitative needs, i.e., as established in the documentation required within these rules, then only the adoption subsidy payment is excluded. The child's eligibility is otherwise determined based upon parental income, the child's income and the appropriate household size. The appropriate category for these cases will be Healthy Start and therefore the language regarding the appropriate application has been changed to reflect the Combined Programs Application (JFS 07216).

The above rule now includes language regarding the Interstate Compact on Adoption and Medical Assistance (ICAMA) to which Ohio is a member state. Member states must ensure that a child who is receiving a state adoption subsidy based on a determination of special medical or rehabilitative needs from one member state continue to receive, at a minimum, the same level of Medicaid eligibility and services if they move to another member state. Each state must designate an ICAMA coordinator as a central point of contact to ensure compliance. Currently, the state coordinator for this compact is located in the Bureau of Family Services/Adoption Services. Specific instructions to CDJFS's will be forthcoming regarding identifying an ICAMA coordinator as contact for the state ICAMA coordinator to facilitate cases entering or leaving Ohio. A View Flash Bulletin will be issued to coincide with the transmittal which will outline specific case processing instructions. This rule replaces former rules 5101:39-74.2 and 5101:1-39-74.9 and Public Assistance Manual Sections: 11219 through 11219.5.

5101:1-40-05: Covered Families and Children Medicaid: Transitional Medicaid

This rule has been rewritten to correct the definition of individuals who are eligible to be covered by Transitional Medicaid. Individuals who are not eligible to be included in a Healthy Families/LIF assistance group (e.g., stepparents and SSI recipients) are not eligible to be included in the Transitional Medicaid assistance group. The exception is that individuals who are ineligible for Healthy Families/LIF due to a third OWF work activity failure pursuant to rule 5101:1-40-07 are eligible to be included in the Transitional Medicaid assistance group. Stepparents and SSI recipients who are currently in a Transitional Medicaid assistance group shall remain in the assistance group until the entire assistance group is no longer eligible for Transitional Medicaid. However, only individuals who meet the definition shall be included in any Transitional Medicaid groups that are opened on or after the effective date of this rule.

5101:1-40-05.1: Covered Families and Children Medicaid: Transitional Medicaid Eligibility Requirements

This rule has been amended to clarify the eligibility requirements for the Healthy Families/LIF assistance group.

5101:1-40-09: Covered Families and Children Medicaid: Living Arrangements

This rule is being revised to address the federal restrictions against certain living arrangements. Correctional facilities are specifically excluded under federal regulations from being considered as residential community facilities. The definition of "residential community group home" is being revised to incorporate the federal restriction. A child born to, or living with, an inmate of a penal or other public institution such as an institute for mental disease, is not considered to be in an inappropriate living arrangement. This would also include a child born in a prison nursery program pursuant to section 5120.65 of the Ohio Revised Code, this child may qualify if otherwise eligible, for CFC Medicaid.

Appendix: Appendix C - Transitional Medicaid (JFS 07115) has been revised.

5101:1-40-22 Covered Families and Children Medicaid: Allocating income to members of an assistance group: This is a new rule regarding allocation of income of certain individuals, i.e., spouses or responsible parents, toward members of an assistance group. This rule replaces the formerly separate rules that dealt with income of a stepparent or parents of a minor caretaker, etc. This rule clarifies the appropriate disregard
and other allowances for the need of the non-assistance group members prior to allocating toward the assistance group. This rule replaces former rules 5101:1-39-78.2, 5101:1-39-78.5 and 5101:1-39-78.6.

The following chart identifies the materials that are to be removed from the Public Assistance Manual (PAM), Chapter 11,000 and new instructions for insertion.

**INSTRUCTIONS**

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<th>LOCATION</th>
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| Chapter 11000 | 5101:1-40-01  
5101:1-40-20.7 | 5101:1-40-01 CFC Medicaid: Assistance groups and definitions  
Effective June 1, 2002 |
| Chapter 11000 | 5101:1-40-01.1 | 5101:1-40-01.1 CFC Medicaid: covered groups  
Effective June 1, 2002 |
Effective June 1, 2002 |
| Chapter 11000 | 5101:1-39-74.2  
5101:1-39-74.9  
PAM 11219 - 11219.5 | 5101:1-40-03 CFC Medicaid: Children in Care  
Effective June 1, 2002 |
Effective June 1, 2002 |
| Chapter 11000 | 5101:1-40-05.1 | 5101:1-40-05.1 CFC Medicaid: Eligibility requirements  
Effective June 1, 2002 |
| Chapter 11000 | 5101:140-09 | 5101:1-40-09 CFC Medicaid: Living arrangements  
Effective June 1, 2002 |
| Chapter 11000 | Pages headed:  
11310 dated November 1, 1995  
11313 dated April 1, 1989 | Page headed 11307.4 dated November 1, 1995 |
| Chapter 11000 | Pages headed:  
11464 dated October 1, 1991  
11464.3 dated October 1, 1991  
11464.6 dated October 1, 1997 | N/A |
| Chapter 11000 | 5101:1-39-78.2  
5101:1-39-78.5  
5101:1-39-78.6 | 5101:1-40-22 CFC Medicaid: Allocating income to members of an assistance group |
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Effective with the issuance of this Manual Transmittal Letter, rules and forms governing the cash assistance programs have been removed from the Public Assistance Manual. Simultaneously, the Cash Assistance Manual (CAM) will be published in hardcopy and online which will now incorporate the rules and forms governing the Ohio Works First, Disability Assistance, Refugee Cash Assistance and Special Programs. Joint rules covering cash and medical programs will remain in both manuals until the Office of Ohio Health Plans creates Medicaid-only rules covering these requirements. Specifically, the joint rules that will remain in the Public Assistance Manual and will also be housed in the Cash Assistance Manual are the following:

- 5101:1-1-03 "Disclosure of Recipient Information, Nondiscrimination, and Treatment of Information Received from the IRS and Social Security Administration"
- 5101:1-1-13 "Assistance Group Records"
- 5101:1-1-14 "Intercounty Transfers"
- 5101:1-1-20 "Public Assistance: Automatic Assignment of Third-Party and Medical Support Payments, Right of Recovery of Third Party Resources, and Role of ODHS and the CDHS Regarding Third Party Resources"
- 5101:1-1-36 "Income and Eligibility Verification System (IEVS) System"
- 5101:1-2-15 "Voter Registration Requirements"
- 5101:1-2-30.1 "Benefit Eligibility: Victims of Trafficking"
- 5101:1-3-29 "Ohio Works First/Medicaid/ADC-Related Medicaid: Denial of Assistance to Individuals Convicted of Fraudulently Misrepresenting Residence."

As the Medicaid-only rules are created, the joint rules will be removed from the Public Assistance Manual only - they will remain in the Cash Assistance Manual.

**INSTRUCTIONS:**

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<td>Notice of Application for Social Security Number, JFS 07355 (insert directly behind the ODHS 3900)</td>
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**CHAPTER 5000 - DISABILITY ASSISTANCE**

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<td><strong>DA: Payments</strong></td>
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<td><strong>Supplemental Security Income (SSI) Case Management Program Objective and Structure</strong></td>
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Appendix to Chapter 5000  |  All forms in the Appendix  |  N/A

CHAPTER 8000 - OWF AND DA  |  Outline of Contents, all rules and all forms in the appendix  |  N/A

**Please Note:** With the issuance of MTL 431 all transmittal letters referring to cash assistance (only) have been removed from the electronic version of the Public Assistance Manual.
Public Assistance Manual Transmittal Letter No. 428

February 15, 2002

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: THOMAS J. HAYES, DIRECTOR

SUBJECT: CHANGES TO HEALTHCHEK AND PREGNANCY RELATED SERVICES (PRS) PROGRAM IMPLEMENTATION PLAN (PIP) REQUIREMENTS

In an effort to simplify the process by which each CDJFS describes how they administer the Healthchek and Pregnancy Related Services (PRS) programs, we are eliminating the requirement that each CDJFS office submit a Program Implementation Plan (PIP) to ODJFS' Office of Ohio Health Plans, Bureau of Consumer and Program Support. Each CDJFS' PIP described their local system for implementing both the Healthchek and PRS programs. The purpose of the PIP was to provide documentation of how the CDJFS conducted each program to ensure that the appropriate program services were provided. Action Change Transmittal (ACT) Letter No. 211 described the policy change through which each CDJFS office was no longer required to submit a PIP. This MTL transmits the Ohio Administrative Code rule changes which support the policy change.

Additionally, Substitute House Bill 473 requires the review of all state agency rules within a five-year period with at least a fifth of each department's rules being reviewed each year. The purpose of this review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the intent of the review is to ensure that rules are clear and concise and written program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Statement of Fiscal Impact on County Agencies: The revisions to the rules in this transmittal do not impose any new requirements on county agencies. Therefore, the implementation of these rule changes result in no fiscal impact on the county agencies.

Statement of Training and Technical Assistance for County Agencies: Eight daylong Healthchek and Pregnancy Related Services technical assistance sessions were held between September 18, 2001 and October 23, 2001. All 88 CDJFS offices were invited and encouraged to attend one of these sessions and space was allotted for a maximum of five representatives from each CDJFS. A total of 74 CDJFS offices chose to send staff to the technical assistance sessions. The policy changes identified in ACT 211 which are now included with the rule changes outlined in this transmittal were one of the topics covered in the technical assistance sessions. No further training or technical assistance sessions on these rules are planned.

The rules in this MTL are being proposed for an effective date of May 1, 2002. This cover letter includes a summary statement of each policy change.

CHAPTER 7000

Rule 5101:1-38-05 - Early and periodic screening, diagnosis and treatment (EPSDT)--"Healthchek" is included with this MTL and is replacing rule 5101:1-2-28 which is being rescinded. As Healthchek services are available to Medicaid-eligible individuals from birth through age 20, regardless of the category of Medicaid they may be eligible for, the new Healthchek rule will be located in a section of the manual devoted to programs and services which are available across multiple categories of Medicaid.

The only major change from rule 5101:1-2-28 to rule 5101:1-38-05 is paragraph (M). In rule 5101:1-2-28, this paragraph dealt with Program Implementation Plan (PIP) requirements. As per ACT 211, those requirements have been changed and the new guidelines are in paragraph (M) of the "new" Healthchek rule, 5101:1-38-05. The former PIP requirement can now be met by a letter signed by the CDJFS director. However, PIPs on file will be retained. Any program changes that would need to be shared with ODJFS can be submitted via a letter as described in this rule. Counties without a current PIP on file should submit a letter via the guidelines set forth in paragraph (M) of rule 5101:1-38-05.
**Rule 5101:1-38-06 - Pregnancy Related Services** is included with this MTL and is replacing rule 5101:1-26-04 which is being rescinded. As Pregnancy Related Services are available to Medicaid-eligible pregnant women regardless of the category of Medicaid they may be eligible for, and as some of the Pregnancy Related Services are available to some pregnant women who are potentially eligible for Medicaid as well, the new Pregnancy Related Services rule will be located in a section of the manual devoted to programs and services which are available across multiple categories of Medicaid.

The only major change from rule 5101:1-26-04 to rule 5101:1-38-06 is paragraph (K). In rule 5101:1-26-04, this paragraph dealt with Program Implementation Plan (PIP) requirements. As per ACT 211, those requirements have been changed and the new guidelines are in paragraph (K) of the "new" Pregnancy Related Services rule, 5101:1-38-06. The former PIP requirement can now be met by a letter signed by the CDJFS director. However, PIPs on file will be retained. Any program changes that would need to be shared with ODJFS can be submitted via a letter as described in this rule. Counties without a current PIP on file should submit a letter via the guidelines set forth in paragraph (K) of rule 5101:1-38-06.

**INSTRUCTIONS:**


Insert into Chapter 7000, immediately after rule 5101:1-38-04 - Outstationing of eligibility workers at disproportionate share hospitals and federal qualified health center, rule 5101:1-38-05 -- Early and periodic screening, diagnosis and treatment (EPSDT)--"Healthchek" and rule 5101:1-38-06 -- Pregnancy related services.

Additionally, remove and file as obsolete rule 5101:1-26-04 - Pregnancy related services, if it is still filed in Chapter 11,000 of your manual.

Remove and file as obsolete Action Change Transmittal (ACT) Letter No. 211, dated August 14, 2001. The subject of ACT 211 was "Changes to Healthchek and Pregnancy Related Services (PRS) Program Implementation Plan (PIP) Requirements." ACT 211 has been rescinded.
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: Gregory L. Moody, Director
SUBJECT: Covered Families and Children Medicaid: Medicaid Eligibility and OWF Sanctions

Policy changes in this MTL are effective October 1, 2001, unless otherwise indicated. This cover letter includes a summary statement of each policy change. Should any changes be made to the rules during the JCARR review period, corrected rules will be sent out with the next MTL.

CHAPTER 11000

5101:1-40-07 - Covered Families and Children Medicaid: Medicaid Eligibility and OWF Sanctions

This rule clarifies that an adult member of an assistance group who is subject to an OWF sanction loses Healthy Family/LIF Medicaid eligibility at the third tier work-related sanction (i.e. because she/he has failed for the third time to comply with a work activity). Prior to proposing to terminate the sanctioned adult's Healthy Families/LIF Medicaid eligibility, the CDJFS must complete a pre-termination review (PTR) of continuing Medicaid eligibility for the sanctioned adult under every other Medicaid category.

The sanctioned adult immediately regains Medicaid eligibility by complying with the work activity. The CDJFS must permit the sanctioned adult to comply immediately without any delay due to the OWF minimum sanction period. Immediately upon compliance, the sanctioned adult shall be eligible for Healthy Families/LIF Medicaid beginning the first day of the month in which he/she complies.

Instructions

Remove and file as obsolete rule 5101:1-40-07 (effective July 1, 2000) and replace with rule 5101:1-40-07 (effective October 1, 2001).
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
ALL FOOD STAMP CERTIFICATION HANDBOOK HOLDERS
FROM: GREGORY L. MOODY, DIRECTOR
SUBJECT: REVISIONS TO THE JFS 07200 and JFS 07501

As a result of required food stamp and Civil Rights changes, the JFS 07200 (formerly the ODHS 7200) and the JFS 07501 (formerly the ODHS 7501) have been revised, with an effective date of August 1, 2001. Rule 5101:1-2-01 has been revised to reflect the name change and is being issued in MTL 425.

ODJFS 07200
It is now titled "Request for Cash, Medical and Food Stamp Assistance". The CRIS-E generated Printed Copy of Information (PCI) is now considered the application for assistance. This allows the removal of certain items from the JFS 07200 that are federally required to be contained in an application document. These items are being added to the PCI. This change does not affect the current application processing provisions contained in the Public Assistance Manual or Food Stamp Certification Handbook.

All references to ODHS and CDHS have been changed to ODJFS and CDJFS.

The following changes have been made to the JFS 07200:

The Food Stamp Fact Sheet has been removed.
The question regarding whether the assistance group has outstanding medical bills has been removed. This information is captured on the AEFMQ and AEFME screens.
The questions regarding whether the assistance group has group health coverage have been removed. This information is are captured on the AEFMQ and AEFMC screens.
The question regarding pregnancy has been added to the box that captures the individuals at the address.
The question regarding whether a household member is a student has been removed. This information is captured on the AEISA screen.
The Child Support Services request if OWF is denied has been removed. This has been moved to the last page of the PCI (before the rights and responsibilities).
Questions regarding self-declaration have been removed This information is currently captured on the AEISD screen.
The rights and responsibilities pages have been removed, since the CRIS-E generated rights and responsibilities pages are issued at the face-to-face interview or a hardcopy JFS 07501 is provided to individuals who have not completed a face-to-face interview or where CRIS-E is not available.
A Primary Language field for the person completing the form has been added.
A question regarding the need of an interpreter if the assistance group member does not speak English or is hearing-impaired, has been added. If an interpreter is needed at the interview, the CDJFS shall offer an interpreter and if one is provided, it will be done so at no charge to the assistance group.
A question regarding the receipt of benefits in other states in the past has been added. This will allow better tracking for TANF assistance issued in other states that is countable towards Ohio’s 36-month time limit, as well as to identify individuals who have participated in the Food Stamp Program in other states as "able-bodied adults without dependents" (ABAWDS).
A box with non-discrimination information, has been added. This information is required by the United States Department of Agriculture.

JFS 07501

The following changes have been made to the JFS 07501 "Rights and Responsibilities":

Information has been added to the "Release of Information on Social Security Number" section of the form as a result of Federal Guidance issued jointly by the Office of Civil Rights, the Department of Health and Human Services and the Department of Agriculture. Specifically, it indicates when a social security number is required.

A new section titled "Information on Citizenship and Immigration Status" has been added as a result of Federal Guidance issued jointly by the Office of Civil Rights, the Department of Health and Human Services and the Department of Agriculture. Specifically, it indicates when verification of citizenship and immigration status is required.

Minor changes have been made to the "Food Stamp Penalty Warning" section, primarily to add the word "benefit" after "Food Stamp", since EBT has replaced the issuance of coupons.

Information has been added regarding voluntarily providing the social security number and other requested information for the Food Stamp Program. Information has been added regarding release of information collected on the applicant, including social security number to Federal, State, and private collection agencies for claims collection action.

A "Civil Rights Information" section has been moved from the JFS 07200 to the JFS 07501.

A new section titled "Prohibition Against Discrimination on the Basis of Disability" has been added as a result of Federal Guidance issued by the Department of Health and Human Services Office for Civil Rights regarding the obligations that Title II and Section 504 of the Rehabilitation Act impose on state and local governments, and on recipients of Federal financial assistance involved in TANF activities. Specifically, this required language will be used by the Office for Civil Rights for compliance reviews and/or investigations of complaints of discrimination on the basis of disability in TANF programs. These requirements are not new and have been part of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990.

A new section titled "Assisting Persons Who Are Limited English Proficient" has been added to include language that an interpreter will be provided for individuals whose primary language is not English or for hearing-impaired individuals.

A new section titled "Questions or Complaints About Your Civil Rights" has been added along with addresses where individuals can file complaints.

PRINTED COPY OF INFORMATION (PCI)

A Service Request Form (SRF) has been written for the following changes to the Printed Copy of Information:

To add the 2nd phone number that is captured on the AEICI screen.

To move the signature lines from the Rights and Responsibilities page to the last page of the actual PCI (the page before the Rights and Responsibilities).

To add another signature line on the last page of the PCI before the Rights and Responsibilities, indicating whether the assistance group wants child support services if the OWF is denied.

To change the CRIS-E generated "Rights and Responsibilities" pages to match the hard-copy JFS 07501. These changes are expected to be in production by August 1, 2001. A view flash bulletin will be provided when these changes have been made.

CHANGES TO CRIS-E

Additional Service Request Forms (SRF) have been submitted to MIS that may change the JFS 07200 in the future. One SRF has been submitted to add language to the AEINH screen which would remove question B from page 3 of the revised JFS 07200. A second SRF has been submitted to add the Food Stamp disqualification questions and responses which is Question C on page 3 of the revised JFS 07200. This will
affect the AEISD screen. A view flash bulletin will be provided when these changes are in production and the JFS 07200 will be revised to remove these questions. (CCN 4708)

INSTRUCTIONS:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>REMOVE AND FILE AS OBSOLETE</th>
<th>INSERT/REPLACEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUBLIC ASSISTANCE MANUAL - CHAPTER 1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outline of Contents to Chapter 1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix to Chapter 1000</td>
<td>Outline of Contents (effective July 1, 2000)</td>
<td>Outline of Contents (effective August 1, 2001)</td>
</tr>
<tr>
<td>Appendix to Chapter 1000</td>
<td>ODHS 7200 (effective July 1, 1999)</td>
<td>JFS 07200 (effective August 1, 2001)</td>
</tr>
<tr>
<td>Appendix to Chapter 1000</td>
<td>ODHS 7501 (effective July 1, 1999)</td>
<td>JFS 07501 (effective August 1, 2001)</td>
</tr>
<tr>
<td>FOOD STAMP CERTIFICATION HANDBOOK - APPENDIX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix 101</td>
<td>ODHS 7200 (effective July 1, 1999)</td>
<td>JFS 07200 (effective August 1, 2001)</td>
</tr>
<tr>
<td>Appendix 102</td>
<td>ODHS 7501 (effective July 1, 1999)</td>
<td>JFS 07501 (effective August 1, 2001)</td>
</tr>
</tbody>
</table>
The ODJFS 7216 Combined Programs Application (CPA) has been revised. The revision is in booklet form and combines three separately-numbered documents that currently stand alone. These documents are the ODHS 7216, "Combined Programs Application," ODHS 7218 "Program Fact Sheet" and the ODHS 7236, "Your Rights and Responsibilities As A Consumer of Medicaid Health Coverage". These items will continue to retain their individual form numbering in order to facilitate future revisions and form needs. The ODJFS 7236 may continue to be ordered as a stand alone form. The ODHS 7218 dated 8/1999 will become obsolete immediately, however, counties have the option to reproduce the ODJFS 7218 dated 8/2000 as needed. Orders for the ODJFS 7216 will be filled with the booklet that includes all three of the above forms.

Effective July 1, 2000, the ODHS (ODJFS) 7216 "Combined Programs Application" (CPA) has been expanded to serve as the application for families applying for Low Income Families Medicaid. Applicants continue to have the option to have their eligibility explored for other programs via the completion of either the ODHS 7200, "Application for Cash, Medical, and Food Stamp Assistance and the interactive interview or the ODHS 7100, "Common Application Form" (CAF). The purpose of the revised ODJFS 7216 is to modify the form to make a more effective application for families seeking Medicaid.

It is important that individuals are aware of the availability of child care, cash and food stamp assistance. Please note that Section I on the ODJFS 7216 serves to advise interested applicants about other programs and the CDJFS will need to immediately follow up on all requests for information on other programs. However, the application for medical assistance must be immediately processed without delay should the person request information/application for other programs.

The current 05/1999 version of the CPA form is acceptable as a valid application. Agencies may exhaust current supplies or use the revised forms immediately. Note that when using the 05/1999 CPA, it continues to require the separate ODHS 7218, "Program Fact Sheet", dated 8/2000, and the ODHS 7236, "Your Rights and Responsibilities As A Consumer of Medicaid Health Coverage" is also required as an accompanying document. The 05/1999 version will be obsolete for purposes of reordering once the ODJFS 7216, 8/2000 is made available. This would also make the ODHS 7218, 8/1999 obsolete as the new CPA includes this information. The 11/1991 version of the CPA is obsolete and will no longer be honored as an acceptable CPA effective 01/01/01. The ODJFS 7216 will no longer be reproduced as a multiply NCR document. Acceptable applications may be an original form, photocopy, fax or screen print from the ODJFS web page.

The ODHS 7216S, Spanish "Combined Programs Application", ODHS 7218S Spanish "Program Fact Sheet", and ODHS 7236S Spanish "Your Rights and Responsibilities As A Consumer of Medicaid Health Coverage" have not been changed. These forms, introduced with MTL #406 shall continue to be valid, acceptable documents until the revised forms have been translated.

Instructions
Remove and file as obsolete from the Appendix to Chapter 1000, the ODHS 7216 (Rev.5/1999) and replace with the corresponding ODJFS 7216 (Rev. 7/2000).

Remove and file as obsolete the ODHS 7218 form dated 8/1999.
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: JACQUELINE ROMER-SENSKY, DIRECTOR
SUBJECT: MTL NO. 418 Rule Omission

OAC Rule 5101:1-40-251 was inadvertently left out of MTL No. 418. This rule replaces former rule 5101:1-39-781.

Also enclosed is an amended Outline of Contents to Chapter 11000.

We apologize for any inconvenience this may have caused.
Policy changes in this MTL are effective July 1, 2000, unless otherwise indicated. This cover letter includes a summary statement of each policy change. Should any changes be made to the rules during the JCARR review period, corrected rules will be sent out with the next MTL.

**Chapter 11000**

The following chart shows rules that have been rescinded and refiled as new rules. Rules that have been rescinded and not refilled are identified by N/A in the column under "New Rule".

<table>
<thead>
<tr>
<th>Rule Rescinded</th>
<th>New Rule</th>
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<tbody>
<tr>
<td>5101:1-39-752</td>
<td>N/A</td>
</tr>
<tr>
<td>5101:1-40-21</td>
<td>N/A</td>
</tr>
<tr>
<td>5101:1-40-205</td>
<td>5101:1-40-205</td>
</tr>
</tbody>
</table>

**Rule 5101:1-39-752 ADC-Related Medicaid: Mandatory cooperation in securing child support and medical support (CCN 4569)**

This rule and its policy have been rescinded.

**Rule 5101:1-40-021 Covered Families and Children Medicaid: Low income families (LIF) and OWF covered groups (CCN 4569)**

This rule has been amended to reflect the elimination of the 185% standard. The 185% standard and the 100% initial eligibility test are no longer part of the financial calculation process when determining eligibility for Covered Families and Children Medicaid covered groups.

**Rule 5101:1-40-07 Covered Families and Children Medicaid: Ineligibility as a result of an OWF sanction (CCN 4569)**

This rule clarifies that adult members of an assistance group who are subject to an OWF sanction lose Medicaid eligibility at the third tier work-related sanction. The Medicaid eligibility of the remaining assistance group members, including that of a pregnant woman, is not affected by the sanction at any tier. There is no minimum sanction period for the adult who has been determined ineligible under this provision. The adult must be given the opportunity to comply (e.g. agree to comply) immediately without delay due to any OWF minimum sanction period.
Ohio Am. Sub. H.B. 283 expanded healthy start coverage to include a new covered group of uninsured children from birth through the age of eighteen. Family countable income must be above 150% of the federal poverty level (FPL) but must not exceed 200% of FPL. The expansion limits coverage to uninsured children who are not financially eligible for any other Medicaid category. An uninsured child is defined as a child without creditable health insurance that covers both physician services and inpatient hospitalization.

A non-refundable annual premium of $25 per child with a $75 maximum per assistance group is a condition of eligibility and must be paid before Medicaid is authorized in CRIS-E. The annual premium is being waived until January 1, 2001. Additional information regarding the premium payment process will be forthcoming in a future MTL.

Once the assistance group is determined eligible, 12 months continuous coverage is authorized. A reapplication is required every 12 months. Income changes do not affect continued eligibility for this covered group.

Rule 5101:1-40-20 Covered Families and Children Medicaid: Income

This rule has been amended to delete and replace all references to ADC-Related Medicaid with Covered Families and Children Medicaid. Paragraph (A)(10) of this rule has been amended to clarify the members of the assistance group who are subject to a sanction. Paragraph (D)(2) of this rule has been amended to eliminate the reference to subtracting "earned" income disregards to determine countable income.


This rule has been rescinded and refiled to clarify allowable disregards of earned income to be applied during the budgeting process to determine financial eligibility for Covered Families and Children Medicaid.

Rule 5101:1-40-207 Covered Families and Children Medicaid: Earmarked income

This rule has been amended to delete and replace all references to ADC-Related Medicaid with Covered Families and Children Medicaid. Language has been added in paragraph (D)(2) to reference rules that set forth allowable disregards in determining financial eligibility for remaining family members when an assistance group contains a child who receives earmarked income.

To help clarify what types of Medicaid coverage are part of Covered Families and Children Medicaid the CRIS-E categories listed below are all included under Covered Families and Children Medicaid:

(1) OWF Medicaid (MA-C)
(2) Low Income Families Medicaid (LIF) - (MA-C)
(3) Four Month Extended Medicaid (MA-C)
(4) Cash failed due to sibling income (MA-S)
(5) Less than 21 (19 and 20 year old) (MA-T)
(6) Cash failed due to stepparent income (MA-H)
(7) Earmarked Income (MA-X)
(8) Transitional Medicaid (MA-Y)
(9) Healthy Start (MA-P)
(10) Expedited Medicaid (MA-Z)

This rule has been amended to delete any separate references to Healthy Start.

RULE 5101:1-40-21 Covered Families and Children Medicaid: Initial eligibility test (CCN 4569)

This rule and its policy have been rescinded.

Rule 5101:1-40-25 Covered Families and Children Medicaid: Low income families medicaid (LIF) budgeting methodologies (CCN 4569)
In compliance with Am. Sub. H.B. 283 rule 5101:1-40-25 has been amended to clarify that effective July 1, 2000 for those assistance groups applying/reapplying for LIF Medicaid and failing the regular budgeting process because of excess income will have their financial eligibility determined using the time limited Healthy Families budgeting methodology.

The time limited Healthy Families budgeting methodology will be used in the LIF Medicaid budgeting process for assistance groups whose total countable income is equal to or exceeds the payment standard for LIF.

The Healthy Families budgeting methodology process compares all nonexempt gross monthly earned and unearned income to the 100% federal poverty level standard for the appropriate assistance group size.

Assistance groups that are determined eligible for LIF Medicaid using the Healthy Families budgeting methodology are eligible to have this methodology applied for a period of 24 months beginning the first month eligibility is established.

The 24 month time limit does not stop when the assistance group is no longer eligible for LIF Medicaid or becomes eligible for Medicaid under another category. Once an assistance group has exhausted the 24 month time limit, they can be eligible again for the time limited Healthy Families budgeting methodology beginning the first of the seventh month following expiration of the time limit. CRIS-E support for tracking the 24 month time limit is to be developed.

Retroactive eligibility for LIF Medicaid using the Healthy Families budgeting methodology cannot precede July 1, 2000.

The following are examples of LIF budgets:

**Example 1:** A family with earned and unearned income applies for LIF Medicaid. The CDHS determines the assistance group is financially eligible using the earned income disregards, including the $250 and one-half of the remainder of earned income disregard.

The 24 month time limit does not start because the time limited Healthy Families budgeting methodology was not used to determine eligibility for LIF Medicaid.

**Example 2:** Husband, wife, 2 common children and the wife’s child from a previous relationship, applies for LIF. The husband is employed with $1,000 monthly earned income. Child support is received in the amount of $250 per month.

The table below is an example of the Healthy Families budgeting methodology, using figures from example 2 above:

<table>
<thead>
<tr>
<th>Step (1)</th>
<th>Determine total countable earned income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 gross countable earned income</td>
<td></td>
</tr>
<tr>
<td>- 250 earned income disregard</td>
<td></td>
</tr>
<tr>
<td>$750</td>
<td></td>
</tr>
<tr>
<td>- 375 earned income disregard</td>
<td></td>
</tr>
<tr>
<td>= $375 total countable earned income</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step (2)</th>
<th>Determine total countable unearned income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250 child support</td>
<td></td>
</tr>
<tr>
<td>- 50 disregard</td>
<td></td>
</tr>
<tr>
<td>= $200 total countable unearned income</td>
<td></td>
</tr>
</tbody>
</table>

| Step | Add total countable earned and unearned income |

The above table provides a clear understanding of how to calculate countable income for eligibility determination under the Healthy Families budgeting methodology.
<table>
<thead>
<tr>
<th>Step (4)</th>
<th><strong>Compare total monthly countable income to the payment standard for the appropriate assistance group size.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$575 total monthly countable income</td>
</tr>
<tr>
<td></td>
<td>539 payment standard</td>
</tr>
<tr>
<td></td>
<td>$36 over income - Proceed to Step (5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step (5)</th>
<th><strong>Determine financial eligibility by applying the time limited Healthy Families budgeting methodology.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total gross countable earned and unearned income</td>
</tr>
<tr>
<td></td>
<td>$1,000 gross countable earned income</td>
</tr>
<tr>
<td></td>
<td>+ 250 gross countable unearned income</td>
</tr>
<tr>
<td></td>
<td>= $1,250 total gross monthly countable income</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step (6)</th>
<th><strong>Compare total gross monthly countable income to the 100% Federal Poverty Level (FPL) standard.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,250 total gross monthly countable income</td>
</tr>
<tr>
<td></td>
<td>1,663 100% FPL standard for AG of 5</td>
</tr>
<tr>
<td></td>
<td>Assistance group is financially eligible for LIF Medicaid using the Healthy Families budgeting methodology, and the time clock for the 24 month period begins.</td>
</tr>
</tbody>
</table>

**Rule 5101:1-40-26 Covered Families and Children: Standards of need and pregnancy allowance (CCN 4569)**

This rule has been revised to (1) delete the 185% standard of need - this is reflected in the 6 standards for computing eligibility for Covered Families and Children Medicaid; (2) add the 200% FPL standard; and (3) update the standards used to determine eligibility for Covered Families and Children Medicaid. The updated standards can be found on CRIS-E Table THST.

**Rule 5101:1-40-60 Expedited Medicaid Eligibility Determinations (CCN 4569)**

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS  
FROM: JACQUELINE ROMER-SENSKY, DIRECTOR  
SUBJECT: JULY 1, 2000 APPLICATION PROCESSING CHANGES

Policy changes in this MTL are effective July 1, 2000. This cover letter includes a summary statement of each policy change. Each statement references the clearance control number (CCN) assigned when the policy change was placed in the clearance process.

CHAPTER 1000

Rule 5101:1-2-01 - Applications and the Application Process for OWF, DA and RRP

As a result of an administrative decision to begin the process of creating a Medicaid specific manual, rules pertaining to application processing of Medicaid assistance groups have been removed from rules in Chapter 1000 and will now be found in Chapter 5101:1-38 of the Administrative Code (Chapter 7000 of the Public Assistance Manual).

All references to application processing of Medicaid assistance groups have been removed from this rule, and will be found in new rule 5101:1-38-012. The list of items to be included in the application packet now reflect new brochures produced by the Office of Communications.

Information regarding the requirement of the CDJFS to offer and to provide an interpreter at no cost to the assistance group has been added in order to comply with Title VI of the Social Security Act (Civil Rights). The CDJFS shall not require the assistance group to use friends or family members as interpreters. However, a family member or friend may be used as an interpreter if this approach is requested by the assistance group member and the use of such a person would not compromise the effectiveness of services or violate the assistance group member's confidentiality, and the assistance group member is advised that a free interpreter is available.

To promote outreach for the Child Care Program, new ODJFS form 1139 "Child Care Application Addendum" has been created. This form is to be included in the application and reapplication packet. When the assistance group member completes the ODJFS 1139, it is recommended that the CDJFS worker include copies of the assistance group's income and forward the application addendum to the appropriate child care eligibility worker. Further instructions on the processing of the application addendum by the child care eligibility worker will be issued in a future guidance letter.

All references to the County Department of Human Services have been changed to the County Department of Job and Family Services in light of the July 1, 2000 merger. (CCN 4583)

Rule 5101:1-2-20 - OWF/DA/RRP - Verification and Reporting Requirements

The only change to this rule is the removal of all references to Medicaid. New rule 5101:1-38-02 reflects the verification and reporting requirements for the Medicaid program. (CCN 4583)

PAM Sections 1600 - 1600.3 - Group Health Insurance

PAM Sections 1600 and subsections are being removed from the PAM. The rule relating to Group Health Insurance has been rescinded.

CHAPTER 7000

Rule 5101:1-38-012 - Medicaid and Covered Families and Children: Application Process

New rule 5101:1-38-012 provides the regulations relating to the application process for Medicaid. This rule is similar to the information contained in rule 5101:1-2-01. This rule also includes information regarding the requirement that the CDJFS provide an interpreter and a list of the required information, including the Child Care Application Addendum, that must be issued with each application and reapplication. A significant
The change in the application process is that the CPA will also be used as an application for assistance for Low-Income Families (LIF) Medicaid. Information has been added about the use of the ODHS 2398 "Program of All-Inclusive Care for the Elderly (PACE) Referral." ODHS 2399 "Home and Community-Based Services (HCBS) Waiver Referral," and ODHS 7120 "Optional State Supplement Referral" forms that are used in conjunction with the application forms.

OAC rule 5101:1-39-13 regarding the intent to file an application via an ODHS 2453 is being rescinded. The information is included in new rule 5101:1-38-012 on application processing. PAM Sections 1015.2 through 1015.5 are being removed from Chapter 1000. The information in these sections is included in rule 5101:1-38-012. (CCN 4569)

Rule 5101:1-38-02 - Medicaid and Covered Families and Children: Verification and Reporting Requirements

New rule 5101:1-30-02 provides the verification and reporting requirements for Medicaid. Significant changes have been made in the verification requirements. Self-declaration of age, identity, social security number, citizenship, residence and living arrangement is acceptable verification unless the information is confusing or contradictory to other information available to the CDJFS. Verification is still required for income, resources, pregnancy, limiting physical factor and third party medical information. (CCN 4569)


The requirements for a social security number have not changed. Each applicant/recipients of Medicaid is required to furnish or apply for a social security number. PAM Sections 7406 and 7406.1 are being removed from the PAM. Information regarding the social security number requirements for Medicaid are in rule 5101:1-38-021. (CCN 4569)

Rule 5101:1-38-04 - Outstationing of Eligibility Workers at Disproportionate Share Hospitals and Federal Qualified Health Centers

PAM Sections 1015.6 through 1015.9 are being obsoleted and replaced with rule 5101:1-38-04, which is now contained in Chapter 7000. (CCN 4569)

Rule 5101:1-38-10 - Medicaid Estate Recovery

New rule 5101:1-38-10 provides information pertaining to Medicaid estate recovery. This rule includes the definition of estate, when an undue hardship waiver to exempt an estate from recovery may be granted, the notice requirements, and that any disputes relating to estate recovery will be resolved through the judicial process. The ODHS 7400 "Estate Recovery" form has been revised. (CCN 4575)
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS  
FROM: JACQUELINE ROMER-SENSKY, DIRECTOR  
SUBJECT: APPLICATION PROCESSING

Rule 5101:1-38-01 is effective May 4, 2000. This cover letter includes a summary of each policy change. This rule has been through the clearance process. Should any changes be made to the rule during the JCARR review period, a corrected rule will be sent out with the next MTL.

CHAPTERS 7000 AND 11000

Rule 5101:1-38-01 - "MEDICAID AND COVERED FAMILIES AND CHILDREN MEDICAID: THE DETERMINATION AND REDETERMINATION OF ELIGIBILITY" (CCN 4566)

This rule was previously issued in MTL 402 and subsequently rescinded in MTL 402-A.

This rule provides the Medicaid specific requirements for the determination and redetermination of Medicaid eligibility. The significant changes in this rule from the requirements that had previously been in rule 5101:1-2-10 are:

Pregnant women in receipt of Medicaid shall remain eligible for medical coverage throughout her pregnancy and the sixty day post-partum period without being required to complete a reapplication.

A reapplication is not required for newborns if the newborn is eligible for Medicaid in accordance with rule 5101:1-40-022. A reapplication is to be scheduled at the end of the one year period of deemed eligibility.

The CDHS must document in the case record the reason(s) for requiring a reapplication at any time other than the 6 month or 12 months reapplication intervals.

For institutionalized Medicaid recipients, the face-to-face interview for a reapplication may be conducted at the institution, by telephone, or at the CDHS with the institutionalized individual or authorized representative as determined by the CDHS.

Effective July 1, 2000, the reapplication period for Healthy Start assistance groups has been increased from 6 months to 12 months.

In multiple assistance cases (e.g., Medicaid, OWF, food stamps), the reapplication date for continued Medicaid eligibility is based on the intervals required for the various categories of Medicaid and may not be the same as the reapplication date for other assistance programs.

Effective July 1, 2000, assistance groups in receipt of Low Income Families Medicaid (LIF) will no longer require a face-to-face interview at either application or reapplication.

Effective July 1, 2000, assistance groups who are eligible for Healthy Start whose income is between 150% and 200% of the federal poverty level will be eligible for 12 continuous months of eligibility.

In addition, the ODHS 7216 Combined Programs Application can be used to apply for LIF.

The rules relating to the proposed changes that will be effective July 1, 2000 will be issued in a later MTL.

A correction has been made to the deeming amount for an ineligible parent in Appendix A.

The Federal Poverty Level (FPL) figures for QMB, SLMB, QI-1, QI-2 and QWDI that are effective April 1, 2000 have been added to Appendix B.

A correction has been made to the excess shelter standard in Appendix D.
Archived MEMMTLs
To: All Medicaid Eligibility Modernization Manual Holders  
From: John B. McCarthy, Director  
Subject: Medicaid: Withdrawal of Presumptive Eligibility Rule  


On February 5, 2014, this rule was withdrawn prior to its effective date. The rule will be re-published in the near future with a new effective date.

MEM Instructions:

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<td>MEMMTL 5A (Effective 02/07/14)</td>
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<td>5160:1-1-62 (Effective 02/10/14)</td>
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This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
Archived MEMTLs

The following Medicaid Eligibility Transmittal Letters (MEMTLs) are being provided for user convenience.
MEMTL 52 (Medicaid: Home and Community-Based [HCB] Services)

Medicaid Eligibility Manual Transmittal Letter No. 52
September 24, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Home and Community-Based (HCB) Services

This MEMTL contains one rule from Chapter 5101:1-38 of the Administrative Code. Rule 5101:1-38-01.6 "Medicaid: home and community-based services", adopted under section 119.03 of the Revised Code, replaces former rule 5101:1-38-01.6. This rule was reviewed in accordance with section 119.032 of the Revised Code.

The effective date of this rule is October 1, 2009.

Chapter 2

5101:1-38-01.6 Medicaid: home and community-based (HCB) services.

This rule is rescinded and replaced with a new rule which is rewritten for clarity. The new rule more clearly states that HCB services are available only to Medicaid-eligible individuals who meet an additional set of conditions for the payment of HCB services. The rule also clarifies that while HCB services are not available before the beginning date of Medicaid eligibility or after Medicaid eligibility ends, coverage for HCB services may not begin or end on the same date as Medicaid eligibility.

MEM Instructions:

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<td>Chapter 2</td>
<td>5101:1-38-01.6 (Effective 10/1/2004)</td>
<td>5101:1-38-01.6 (Effective 10/1/2009)</td>
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ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEMTL 46A (Medicaid: Medicaid Extension for Elderly or Disabled Refugees)

Medicaid Eligibility Manual Transmittal Letter No. 46A

March 26, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Medicaid Extension for Elderly or Disabled Refugees

This MEMTL amends and makes permanent rule 5101:1-38-02.6 of the Administrative Code, which was emergency filed on January 5, 2009.

The effective date of this rule is April 1, 2009.

**Chapter 2**

Medicaid: 5101:1-38-02.6 Medicaid Extension for Elderly or Disabled Refugees

This rule is replacing the emergency filing of the same rule. Minor changes were made to the emergency rule in order to clarify definitions and to more clearly differentiate between those aliens qualified for a two-year extension and those qualified for a three-year extension. See MEMTL #46, dated January 12, 2009.

**MEM Instructions:**

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</table>

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**ODJFS Electronic Manuals**

http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEMTL 46 (5101:1-38-02.6 Medicaid: Medicaid Extension for Elderly or Disabled Refugees)

Medicaid Eligibility Manual Transmittal Letter No. 46
January 12, 2009

To: All Medicaid Eligibility Manual Holders
From: Jan Allen, Interim Director
Subject: Medicaid: Medicaid Extension for Elderly or Disabled Refugees

House Resolution 2608, recently signed into law as Public Law 110-328, extends the seven-year eligibility limit to nine years for SSI and Medicaid for elderly or disabled refugees. This MEMTL contains one new rule from Chapter 5101:1-42 of the Ohio Administrative Code. Rule 5101:1-38-02.6 "Medicaid: medicaid extension for elderly or disabled refugees" is a new rule adopted under the emergency provisions of division (B)(2) of section 111.15 of the Ohio Revised Code and establishes eligibility requirements for elderly or disabled refugees.

The effective date of this rule is January 5, 2009.

Chapter 2
Medicaid: 5101:1-38-02.6 Medicaid Extension for Elderly or Disabled Refugees

Public Law 110-328 extends Medicaid eligibility beyond the seven-year limit for certain elderly or disabled refugees who are receiving supplemental security income (SSI). This is a new rule implementing the changes made necessary by the federal legislation.

The eligibility period for SSI and Medicaid is time-limited from October 1, 2008 to September 30, 2011. Elderly or disabled refugees may receive up to two additional years of Medicaid, while aliens awaiting naturalization may receive Medicaid for the duration of the time-limited eligibility period.

An elderly or disabled refugee, who is not currently receiving Medicaid, must apply for Medicaid. Upon request by the elderly or disabled refugee, the administrative agency shall explore retroactive coverage, as described in rule 5101:1-38-01.3 of the Administrative Code. Retroactive coverage is not available before October 1, 2008.

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**ODJFS Electronic Manuals**
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http://www.odjfs.state.oh.us/lpc/calendar/
MEMTL 44 (Children's Buy-in Program: Eligibility)

Medicaid Eligibility Manual Transmittal Letter No. 44

April 2, 2008

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Children's Buy-in Program: Eligibility

Amended Substitute House Bill 119 of the 127th General Assembly created a new program called the Children's Buy-in (CBI) Program. The CBI Program expands access to health care coverage for children in families earning more than 300% of the federal poverty level (FPL). The CBI Program is a state-funded, non-Medicaid program and is not subject to federal regulations governing Medicaid.

This MEMTL contains one new rule from Chapter 5101:1-42 of the Ohio Administrative Code. This rule was adopted under the emergency provisions of division (F) of section 119.03 of the Ohio Revised Code and establishes eligibility requirements for the CBI Program.

Effective Date: April 1, 2008

Chapter 5

5101:1-42-30 Children's buy-in program: eligibility

This rule was adopted to establish eligibility standards for the CBI Program. The rule also defines key terms, sets forth premium amounts, and outlines individual and administrative agency responsibilities.

Highlights of the rule and other procedural matters related to the CBI Program include the following:

- The CBI Program is not a county-administered program.
- All notices regarding an individual's participation in the CBI Program, including termination notices, will be electronically generated. For this reason, individuals will be required to maintain an e-mail account. Notices will not be sent by U.S. mail.
- ODJFS may suspend application or enrollment in the CBI program, and may disenroll individuals, as necessary based on available state appropriations.
- An individual interested in purchasing coverage under the CBI Program will apply online on or after April 1st using the HealthLink Information Exchange (HIEx) system. A link to HIEx will be provided on the Ohio Department of Job and Family Services (ODJFS) Office of Ohio Health Plans' (OHP) website, accessible at http://jfs.ohio.gov/ohp/cbi. A FAQ and a help desk number (866-221-7976) are available for persons requiring application assistance.
- There is no face-to-face interview for the CBI Program. Applicants will self-declare requested information during the online application process. An eligibility determination will be made by HIEx for ODJFS after all necessary information is provided.
- An individual interested in applying for CBI has an opportunity to perform a "pre-screening" before making an official application to the CBI Program. The pre-screening will indicate whether the individual meets the eligibility requirements and, if eligible, the premium amount the individual would have to pay in order to purchase health care coverage under the CBI Program.
- To be eligible to purchase health care coverage under the CBI Program, an individual must:
  1. Be under nineteen years of age;
  2. Be an Ohio resident and a U.S. citizen;
  3. Have countable family income over 300% of the FPL (with no disregards or exemptions, except for earnings from full-time students);
  4. Have been without creditable coverage (with the exception of Medicaid) for six months;
5. Not be eligible for Medicaid; and
6. Meet one of the following conditions: a) Be unable to obtain creditable coverage due to a pre-existing condition; b) Have lost the only creditable coverage available due to exhaustion of a lifetime benefit; c) The premium for the only creditable coverage available is more than two times the cost of the premium under the CBI Program; or d) Participate in the program for medically handicapped children.

- An individual must pay a premium. An individual's countable family income will determine the amount of the premium.

- Health care coverage is provided by a managed care plan (MCP) and will not begin until the first day of the month following receipt of the initial premium payment. An ID card will be issued by the MCP after the first premium payment is received.

- Failure to pay premiums for two consecutive months will result in termination of health care coverage. To resume health care coverage, the individual must reapply and pay any premium amounts past due.

- Premium payment notices will be generated by a premium collection vendor under contract with ODJFS.

- An individual must report online to HIEx any changes affecting eligibility or the premium amount. An annual redetermination may be required.

- If an individual no longer wishes to purchase coverage under the CBI Program, the individual must notify HIEx online at least thirty days prior to the desired date of discontinuation.

- An individual who disagrees with an eligibility decision may request a reconsideration by filing a written request with ODJFS within fifteen calendar days after the date of the notice.

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**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

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http://www.odjfs.state.oh.us/lpc/calendar/
MEMTL 42 (Medicaid: Standards of Need)

Medicaid Eligibility Manual Transmittal Letter No. 42

February 21, 2008

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Standards of Need

Am. Sub. H.B. 119 expanded coverage for pregnant women from 150% to 200% of the federal poverty level (FPL) for her family size and removed the 24-month clock on low income family (LIF) budgeting. Those changes were accomplished through revisions of rules contained in MEMTL’s 39 and 40. Rule 5101:1-40-26 is being revised to more clearly reflect the standards in rules 5101:1-40-08 and 5101:1-40-25. This rule was reviewed in accordance with section 119.032 of the Revised Code.

Effective date: March 1, 2008

Chapter 4

5101:1-40-26 Medicaid: standards of need

This rule is being amended to state that the standards for LIF Medicaid are set out in rule 5101:1-40-25 and that, as set out in rule 5101:1-40-08, if a pregnant woman has income between 150% and 200% of the FPL for her family size, then the income will be disregarded in the amount of the difference between 150% and 200% of the FPL for her family size when determining eligibility as a pregnant woman.

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MEMTL 40 (Coverage for Children and Pregnant Women)

Medicaid Eligibility Manual Transmittal Letter No. 40

December 24, 2007

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Coverage for Children and Pregnant Women

Am. Sub. H.B. 119 expanded coverage for pregnant women from 150% to 200% of the federal poverty level (FPL) for her family size. Rule 5101:1-40-08 is being rescinded and replaced in order to reflect this change. This rule was reviewed in accordance with section 119.032 of the Revised Code.

Effective date: January 1, 2008

Chapter 4

5101:1-40-08 Medicaid: coverage for children and pregnant women

This rule is being changed to raise the income limit for a pregnant woman to 200% of the FPL for her family size. The entire rule has been rewritten for clarity, and "creditable coverage" has been defined (for children with family income over 150% of FPL). No other substantive changes have been made to eligibility for pregnant women or children with family income up to 200% of FPL.

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MEMTL 39 (Medicaid: Low Income Families)

Medicaid Eligibility Manual Transmittal Letter No. 39

December 24, 2007

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Low Income Families

Am. Sub. H.B. 119 removed the 24-month time limit on eligibility for low income families (LIF) Medicaid for parents with family income of no more than 90% of the federal poverty level (FPL). Rule 5101:1-40-05 is being amended, and rule 5101:1-40-25 is being rescinded and replaced in order to reflect this change.

These rules were reviewed in accordance with section 119.032 of the Revised Code.

Effective date: January 1, 2008

Chapter 4

5101:1-40-05 Medicaid: transitional medicaid

This rule is being amended to reflect the fact that low income families will no longer be subject to a 24-month limit, and therefore will not become eligible for transitional Medicaid as a result of time-limited budgeting. Some definitions have also been added to the rule.

5101:1-40-25 Covered families and children medicaid: low income families (LIF)

This rule is being changed to reflect the removal of the 24-month time limit for LIF Medicaid. The two-step budgeting process has not changed, except that there is no longer a time limit on how long an individual can be eligible when a family’s gross nonexempt income is no more than 90% FPL. To be Medicaid-eligible under this rule, an individual must be the parent of and residing with a child; a child’s eligibility is determined under other Medicaid rules, including rule 5101:1-40-08 "Medicaid: coverage for children and pregnant women".

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http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: 5101:1-38-02 Medicaid: Verification and Reporting Requirements

This Medicaid Eligibility Manual Transmittal Letter amends rule 5101:1-38-02 of the Administrative Code to include additional groups excluded from the citizenship verification and reporting requirement and to clarify this requirement for newborns.

Chapter 2
Medicaid: Verification and Reporting Requirements 5101:1-38-02

The Deficit Reduction Act of 2005 required verification of U.S. citizenship for all applicants and recipients of Medicaid except for those individuals already enrolled in Medicare or receiving SSI. Amended federal legislation now requires that we exclude additional groups from the citizenship verification requirement. Effective 9/25/2006, individuals receiving foster care or adoption assistance under Title IV-E, those in foster care receiving child welfare services under Title IV-B, and those receiving Social Security Disability Insurance (SSDI) are also excluded from this requirement. Clarification of the citizenship verification and reporting requirement as it pertains to newborns has also been added to the rule.

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MEMTL 25 (Disability Medical Assistance (DMA) Program

Medicaid Eligibility Manual Transmittal Letter No. 25

December 19, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Disability Medical Assistance (DMA) program

Rule 5101:1-42-01 of the Administrative Code is a new rule that will replace the existing Disability Medical Assistance (DMA) rule. In addition to the revised DMA rule, the Medicaid eligibility section revised the JFS form that a physician is required to sign to certify that an individual meets the definition of "medication dependency", the JFS 03606.

The effective date of this MEMTL is January 1, 2006.

Background:

In accordance with Medicaid Information Letter (MIL) 04-015, the Disability Medical Assistance (DMA) program is under an Administrative Order to suspend the approval of all applications for DMA. Under this administrative order, all county departments of job and family services (CDJFS) shall deny all new applications for the DMA program until the order is revised or rescinded.

The DMA program is a state administered program with no federal funding. Because DMA is funded with 100% state resources, ODJFS has taken aggressive steps to contain costs within the program. In July 2005, Amended Substitute House Bill (HB 66), Ohio’s Biennial Budget Bill, authorized the continuance of the DMA program and the creation of the Disability Medical Assistance Council.

The DMA Council prepared a report with recommendations for the DMA replacement program and provided it to the Ohio General Assembly on September 1, 2005. Rule 5101:1-42-01 of the Administrative Code and the form to certify "medication dependency" have been revised accordingly.

Chapter 5

5101:1-42-01 Disability Medical Assistance (DMA) Program

Significant changes to this rule are:

1. A revised definition of "medication dependency", in paragraph (B);
2. A requirement for the CDJFS to explore medicaid eligibility at the time of application or redetermination for DMA eligibility, in paragraph (F);
3. A requirement for individuals to apply for any disability benefits to which they may be entitled as a condition of DMA eligibility, in paragraph (F); and
4. Removal of the pre-termination review (PTR) requirement for Medicaid or medical assistance prior to terminating a DMA case.

NOTE: There is a significant policy change with regard to conducting a pre-termination review (PTR) prior to terminating DMA eligibility. The previous rule (effective September 5, 2003) did not permit the county agency to terminate DMA until a pre-termination review of continuing eligibility for Medicaid was completed. This requirement to conduct a pre-termination review prior to terminating DMA eligibility is eliminated effective January 1, 2006. At DMA redeterminations on or after January 1, 2006, if the individual no longer meets the DMA eligibility criteria, the county agency must propose termination of DMA. This means that the county agency must propose DMA termination even if there is a Medicaid eligibility determination pending.
Appendix

JFS Forms

The JFS 03606, "Disability Medical Assistance (DMA) Physician Certification of Medication Dependency" is revised to reflect the revised definition of "medication dependency".

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This information is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/oheligibility/MEM

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http://www.odjfs.state.oh.us/lpc/calendar
MEMTL 21 (Coverage for Children Born to Medicaid Eligible Women)

Medicaid Eligibility Manual Transmittal Letter No. 21

June 20, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Coverage for children born to medicaid eligible women

This MEMTL contains one rule from Chapter 5101:1-40 of the Administrative Code.

Effective date: July 1, 2005

Chapter 4


This new rule replaces current rule 5101:1-40-02.2 of the Administrative Code "Covered families and children Medicaid: coverage for newborns." This new rule defines how the administrative agency shall deem Medicaid eligibility to a child born to a woman eligible for and receiving Medicaid on the date of the child's birth. This new rule also has format changes to make it consistent with other new rules in the Medicaid Eligibility Manual (MEM).

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This information is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjs.state.oh.us/lpc/calendar/
MEMTL 5 (Determination and Redetermination, Application Process, . . . )

Medicaid Eligibility Manual Transmittal Letter No. 5

May 22, 2003

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director


- The rules contained in this Medicaid Eligibility Manual Transmittal Letter (MEMTL) reflect changes in the Healthy Start program regarding the annual premium and twelve months of continuous eligibility. The provisions being removed were originally included in the rules pending approval of a federal waiver. We have made an administrative decision to not move forward on these waiver provisions. This MEMTL further removes old language and clarifies rule language.

- The effective date of this MEMTL is June 1, 2003. If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at:
http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at:
http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at:
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Chapter 2

Medicaid: The Determination and Redetermination of Eligibility - 5101:1-38-01

This rule has been revised to better reflect the delinkage of Medicaid from cash assistance as well as to remove references to twelve months of continuous coverage for the assistance group whose countable income is over one hundred and fifty per cent but less than or equal to two hundred per cent to the federal poverty level.

References to the Qualified Individuals-2 (QI-2) category are being removed from rules regarding redetermination because this program ended December 31, 2002. Reference Action Transmittal Letters (ACT) 221 and 223 for specific information on the QI-1 and QI-2 categories of Medicaid.

Language has also been included to clarify that there is not a face to face interview requirement at redetermination for individuals who are institutionalized or are in receipt of home and community based waiver services

Medicaid: Application Process - 5101:1-38-01.2

This rule has been revised to better reflect the delinkage of Medicaid from cash assistance. This rule also includes the JFS 01137, "Child Care/Healthy Start, Healthy Families Supplement" as a Medicaid application when accompanied by the JFS 01138 Child Care Application to be considered a complete application. Counties may optionally offer this as an application.

Chapter 4

Medicaid: Healthy Start - 5101:1-40-08

This rule has also been revised to remove references to the annual premium as a condition of eligibility for healthy start and removing language regarding twelve months of continuous eligibility for children whose countable assistance group monthly income is between one hundred fifty one and two hundred per cent of the federal poverty level.

Medicaid: Standards of Need and Pregnancy Allowance - 5101:1-40-26
This rule was revised to obsolete the chart referencing the six standards for computing eligibility for covered families and children Medicaid. The rule continues to reference the standards for computing eligibility for each eligible category.

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MEMTL 4 (PTR, OWF eligible for medicaid, and Transitional Medicaid)

Medicaid Eligibility Manual Transmittal Letter No. 4

May 22, 2003

To: All Medicaid Eligibility Manual Holders

From: Thomas J. Hayes, Director

Subject: Medicaid: Pre-Termination Review, OWF recipients eligible for medicaid, and Transitional Medicaid

The rules in this MEMTL reflect changes made as a result of the five-year review. Language in the pre-termination review rule reflects clarifications to the pre-termination review process for all categories of medicaid. "OWF recipients eligible for medicaid" is being reissued with no changes. Transitional medicaid rules have been consolidated into one rule and restructured to make the rules clear and concise as written and reflect federal statutory requirements.

The effective date of this MEMTL is August 1, 2003. If there are changes made to rules contained in this MEMTL during the JCARR review period, corrected rules will be released in a subsequent MEMTL.

This MEMTL is available on the Internet and may be accessed at: http://dynaweb.oddfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/. The calendar provides a daily list of transmittal letters with links to the electronic manuals and to printable (PDF) versions of the transmittal letters.

Chapter 2 Application Processing

Rule 5101:1-38-01.1: "Medicaid: pre-termination review of continuing medicaid eligibility." This rule is being rescinded and reissued, to clarify the pre-termination review requirements for all categories of medicaid. Key points regarding PTR include:

- Medicaid administrative agencies must review medicaid eligibility for an assistance group or member(s) of an assistance group prior to terminating the medicaid benefits for that assistance group or member(s) of that assistance group.

- If there is no continuing medicaid eligibility for the assistance group, a PTR must be completed for each member of the assistance group to determine if there is eligibility for any member of the assistance group.

- The administrative agency must document the PTR process in the assistance group's case record or electronic format.

Chapter 4 Covered Families and Children (CFC)

Rule 5101:1-40-02: "Covered families and children medicaid: OWF recipients eligible for medicaid." This rule has been reviewed in accordance with Substitute House Bill 473, requiring the review of all state agency rules within a five-year period. This rule was waived from clearance review, as no changes were been made.

Rule 5101:1-40-05: "Covered families and children medicaid: transitional medicaid." This rule has been reviewed in accordance with Substitute House Bill 473, requiring the review of all state agency rules within a five-year period. This rule is being rescinded and reissued, to clarify transitional medicaid and incorporate contents of former rules 5101:1-40-05.1, 5101:1-40-05.2, 5101:1-40-05.3, and 5101:1-40-05.4. Transitional medicaid rules have been consolidated into one rule and restructured to make the rules clear and concise as written and reflect federal statutory requirements. Key points regarding transitional medicaid include:

- The transitional medicaid assistance group must have lost healthy families/LIF eligibility either due to earned income of an amount that brings the total income in excess of the healthy families/LIF standard, or the parent or specified relative has earned income of any amount and eligibility for the twenty-four
month limited healthy families/LIF budgeting methodology (as set forth in paragraph (B) of rule 5101:1-40-25 of the Administrative Code) has expired and the family's countable income exceeds the healthy families payment standard as described in rule 5101:1-40-26 of the Administrative Code.

- Eligibility for the first six month period of transitional medicaid begins the month immediately following the last month of healthy families/LIF eligibility. If healthy families/LIF continues beyond the last month of healthy families/LIF eligibility, the months of coverage beyond eligibility are counted as months of the transitional medicaid period of eligibility.
- Eligibility for transitional medicaid ends if the transitional medicaid assistance group regains eligibility for healthy families/LIF.
- The administrative agency shall not terminate medicaid for any assistance group or members(s) of an assistance group until a pre-termination review (PTR) of continuing medicaid eligibility has been completed in accordance with rule 5101:1-38-01.1 of the Administrative Code.
- Transitional medicaid assistance groups that have coverage terminated prior to the completion of the twelfth month of transitional medicaid may potentially reestablish transitional medicaid coverage.

Rules 5101:1-40-05.1: "Transitional medicaid: eligibility requirements," 5101:1-40-05.2: "Quarterly income reporting requirements for transitional medicaid," 5101:1-40-05.3: "Termination from and return to transitional medicaid," and 5101:1-40-05.4 "Transitional medicaid pre-termination reviews and terminations" have been reviewed in accordance with Substitute House Bill 473, requiring the review of all state agency rules within a five-year period. These rules are being rescinded. Requirements of these rules have been included in rule 5101:1-40-05.

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<tr>
<td>Chapter 4</td>
<td>Rule 5101:1-40-05.1: &quot;Covered families and children medicaid: transitional medicaid: eligibility requirements.&quot;</td>
<td>8/30/2002</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Rule 5101:1-40-05.2: &quot;Quarterly income reporting requirements&quot;</td>
<td>1/26/1998</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Rule 5101:1-40-05.3: &quot;Termination from and return to transitional medicaid.&quot;</td>
<td>1/26/1998</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Rule 5101:1-40-05.4: &quot;Transitional medicaid pre-termination reviews and terminations&quot;</td>
<td>7/1/2000</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Archived MEPLs

The following Medicaid Eligibility Procedure Letters (MEPLs) are being provided for user convenience.
Medicaid Eligibility Procedure Letter No. 88

February 19, 2014

Effective Date: January 1, 2014
OAC Rules: 5160:1-5-30
To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: 2014 Federal Poverty Level Income Guidelines for Medicaid Buy-In for Workers with Disabilities (MBIWD)

Reason for Change: On January 22, 2014, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guideline for the MBIWD program has changed effective January 1, 2014.

Actions Required: Beginning January 1, 2014, the CDJFS must determine initial and ongoing eligibility for the MBIWD individual using the updated 250% FPL income guideline below:

<table>
<thead>
<tr>
<th>MBIWD 2014 Monthly FPL Income Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Income Guideline 250%</td>
</tr>
<tr>
<td>$2,432</td>
</tr>
</tbody>
</table>

Beginning January 1, 2014, the CDJFS must determine MBIWD premiums using the updated 150% and 450% FPL guidelines below:

<table>
<thead>
<tr>
<th>2014 Monthly FPL Income Guidelines for Premium Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

A mass change will not be run for MBIWD individuals; however, instructions regarding how to generate the necessary reports using the Business Intelligence Channel (BIC) are available in the Medicaid Eligibility Manual in a desk aid entitled, “MBIWD FPL BIC Report Instructions.” The data needed to generate this report will be available in BIC in the very near future.

For any assistance groups (AG’s) identified as denied or terminated since January 1, 2014, using the previous year’s FPL income guidelines, counties must redetermine eligibility using the updated FPL, which are also found in CRIS-E table MEP. To determine whether eligibility needs to be redetermined in an AG listed on the closure report:

1. Verify why the AG was listed on the report by looking at AEWAA history screens for the authorization date and reason code(s). If the AG was denied or terminated due to income, go on to step 2.
2. Review IQCT: If AEORE or AEABC was last run before February 18, 2014, re-run the AG to redetermine eligibility.

For individuals who are already approved for MBIWD, the CDJFS is required to rerun the budgets, which includes recalculating the premium. When the CDJFS has determined that the updated premium is lower, the CDJFS must reduce the individual’s premium obligation; however, if the updated premium is higher, the CDJFS shall not increase the premium until the MBIWD individual’s annual redetermination.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table TMEP.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 77 (Effective March 1, 2013)</td>
<td>MEPL 88 (Effective January 1, 2014)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 77 is obsolete upon the effective date of this MEPL.

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 87 (Medicaid: 2014 Federal Poverty Level Income Guidelines for Low-Income (MPAP))

Medicaid Eligibility Procedure Letter No. 87

February 19, 2014

Effective Date: March 1, 2014
OAC Rules: 5160:1-3-01.1, 5160:1-3-01.2, and 5160:1-3-21
To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: 2014 Federal Poverty Level Income Guidelines for Low-Income Medicare Premium Assistance Programs (MPAP)

Reason for Change: On January 22, 2014, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: Federal poverty level income guidelines for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective March 1, 2014.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRIS-E in table TMEP. The increased amounts for 2014 are in bold print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>$973</td>
<td>$1,311</td>
</tr>
<tr>
<td>100% FPL</td>
<td>$958 (2013)</td>
<td>$1,293 (2013)</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB)</td>
<td>$1,167</td>
<td>$1,573</td>
</tr>
<tr>
<td>120% FPL</td>
<td>$1,149 (2013)</td>
<td>$1,551 (2013)</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1)</td>
<td>$1,313</td>
<td>$1,770</td>
</tr>
<tr>
<td>135% FPL</td>
<td>$1,293 (2013)</td>
<td>$1,745 (2013)</td>
</tr>
<tr>
<td>Qualified Working Disabled Individuals (QWDI)</td>
<td>$1,945</td>
<td>$2,622</td>
</tr>
<tr>
<td>200% FPL</td>
<td>$1,915 (2013)</td>
<td>$2,585 (2013)</td>
</tr>
</tbody>
</table>

Action Required: Table TMEP will be updated before CRIS-E’s adverse action cut off for March budgets. The change will automatically recalculate budgets on authorized assistance groups (AG’s). For AG’s where the mass change was not completed, the system generates alert #372 instructing the case manager to rerun the budgets. Counties must rerun these AG’s to update the cost-of-living adjustment (COLA) increases.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 76</td>
<td>MEPL 87</td>
</tr>
<tr>
<td></td>
<td>(Effective March 1, 2013)</td>
<td>(Effective March 1, 2014)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 76 is obsolete upon the effective date of this MEPL.
This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 86 (Medicaid: 2014 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and MAGI-Based Medicaid)

Medicaid Eligibility Procedure Letter No. 86
February 19, 2014

Effective Date: January 1, 2014
OAC Rules: 5160:1-4-02.1, 5160:1-4-02.2, 5160:1-4-02.3, and 5160:1-4-20
To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: 2014 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and MAGI-Based Medicaid

Reason for Change: On January 22, 2014, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guidelines for the Healthy Families, Healthy Start, and MAGI-Based Medicaid programs have changed effective January 1, 2014.

Action Required: Beginning January 1, 2014, the CDJFS must determine initial and ongoing eligibility for Healthy Families and Healthy Start using the following FPL income guidelines:

### 2014 Monthly Federal Poverty Level Income Guidelines

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Families 90%</th>
<th>Healthy Start 150%*</th>
<th>Pregnant Women &amp; Healthy Start 200%**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$876</td>
<td>$1,459</td>
<td>$1,945</td>
</tr>
<tr>
<td>2</td>
<td>$1,180</td>
<td>$1,967</td>
<td>$2,622</td>
</tr>
<tr>
<td>3</td>
<td>$1,485</td>
<td>$2,474</td>
<td>$3,299</td>
</tr>
<tr>
<td>4</td>
<td>$1,789</td>
<td>$2,982</td>
<td>$3,975</td>
</tr>
<tr>
<td>5</td>
<td>$2,094</td>
<td>$3,489</td>
<td>$4,652</td>
</tr>
<tr>
<td>6</td>
<td>$2,398</td>
<td>$3,997</td>
<td>$5,329</td>
</tr>
</tbody>
</table>

*This standard is used for children with creditable insurance.

**This standard is used for children without creditable insurance.

Beginning January 1, 2014, the CDJFS must determine initial and ongoing eligibility for MAGI-Based Medicaid using the following FPL income guidelines:

### 2014 Monthly Federal Poverty Level Income Guidelines

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Individuals Age 19 or 20 44%</th>
<th>Parent or Caretaker Relative 90%</th>
<th>MAGI Adults 133%</th>
<th>Coverage for Children 156%*</th>
<th>Pregnant Women 200%</th>
<th>Coverage for Children 206%**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$428</td>
<td>$876</td>
<td>$1,294</td>
<td>$1,518</td>
<td>$1,945</td>
<td>$2,004</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>$577</td>
<td>$1,180</td>
<td>$1,744</td>
<td>$2,045</td>
<td>$2,622</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$726</td>
<td>$1,485</td>
<td>$2,194</td>
<td>$2,573</td>
<td>$3,299</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$875</td>
<td>$1,789</td>
<td>$2,644</td>
<td>$3,101</td>
<td>$3,975</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$1,024</td>
<td>$2,094</td>
<td>$3,094</td>
<td>$3,629</td>
<td>$4,652</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>$1,173</td>
<td>$2,398</td>
<td>$3,544</td>
<td>$4,157</td>
<td>$5,329</td>
<td></td>
</tr>
</tbody>
</table>

*This standard is used for children with creditable insurance.

**This standard is used for children without creditable insurance.

A mass change will not be run for these individuals; however, the Healthy Families/Healthy Start/Transitional Medical Assistance Closure Report is available in the Business Intelligence Channel (BIC). A desk aid called “CFC FPL BIC Report Instructions” in the Medicaid Eligibility Manual (MEM) describes how to generate the closure report. The data needed to generate this report will be available in BIC in the very near future.

For any assistance groups (AG’s) identified as denied or terminated using the previous year’s FPL income guidelines, counties must redetermine eligibility using the new FPL income guidelines contained in table THST. To determine whether eligibility needs to be redetermined in an AG listed on the closure report:

1. Verify why the AG was listed on the report by looking at AEWAA history screens for the authorization date and reason code(s). If the AG was denied or terminated due to income, go on to step 2.

2. Review IQCT: If AEORE or AEABC was last run before February 18, 2014, re-run the AG to redetermine eligibility.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current Healthy Families and Healthy Start income standards can be found in CRIS-E reference table THST.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 75 (Effective January 1, 2013)</td>
<td>MEPL 86 (Effective January 1, 2014)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 75 is obsolete upon the effective date of this MEPL.

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 85A (Medicaid: Hospital Presumptive Eligibility for MAGI Adults)

Medicaid Eligibility Procedure Letter No. 85A

February 10, 2014

Effective Date:  February 7, 2014
To:        All Medicaid Eligibility Manual Holders
From:      John B. McCarthy, Director
Subject:   Medicaid: Hospital Presumptive Eligibility for MAGI Adults

New Policy: On January 29, 2014, MEPL 85 was published with an effective date of February 10, 2014. It described presumptive eligibility determinations to be made by hospitals.

With the publishing of this Procedure Letter, MEPL 85 is withdrawn prior to its effective date. It will be re-published under a new MEPL number in the near future, with a new effective date.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 85 (Effective 2/10/14)</td>
<td>MEPL 85A (Effective 2/7/14)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 83 (2014 Social Security Cost of Living Adjustment {COLA})

Medicaid Eligibility Procedure Letter No. 83

December 3, 2013

Effective Date: January 1, 2014


To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: 2014 Social Security Cost of Living Adjustment (COLA)

State Minimum Wage Increase
Home Equity Value Increase
Consumer Price Index (CPI) Increase
Supplemental Security Income (SSI) Benefit Increase
Railroad Retirement Benefit Increase
Residential State Supplements (RSS) COLA Disregard
Medicare Part B Premium Change
Medicaid Need Standards Increase
Special Income Level (SIL) Increase
Assisted Living Maintenance Needs Allowance (ALMNA) Increase
Special Individual Maintenance Needs Allowance (SIMNA) Increase
Spousal Impoverishment Standards Increase
MBIWD Resource Eligibility Limit Increase
Medicare Premium Assistance Program (MPAP) Resource Limit Increase
Student Child Earned Income Exclusion Increase
Personal Needs Allowance (PNA) Increase

Reason for Change: ODM is required to make annual adjustments—based on the Social Security COLA and changes to the Consumer Price Index (CPI)—to the following: Social Security income, SSI, railroad retirement benefits, the RSS disregard, Medicare Part B premium, the home equity value limit, spousal impoverishment standards, Medicaid need standards, special income level, assisted living maintenance needs allowance, special maintenance needs allowance, MBIWD resource eligibility limit, MPAP resource limit and changes in the student child earned income exclusion.

ODM is required to annually update the state minimum wage, based upon the Ohio Department of Commerce Division of Industrial Compliance and Labor's annual increase to the state minimum wage.

ODM is required to increase the Personal Needs Allowance (PNA) for nursing facility residents in 2014, per Amended Substitute House Bill 59 of the 130th General Assembly.
The tables in this MEPL have limits, standards, benefits, and/or payment amounts for 2014 in bold, along with the 2013 numbers for reference.

Social Security and railroad retirement benefits will increase by 1.5% January 1, 2014. The 2014 COLA increase for Social Security and railroad retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals until February 28, 2014. For QMB or SLMB individuals, the COLA is only disregarded for the QMB or SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individuals' Social Security benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 1.5% COLA.

In 2014, there will also be increases in the home equity limit, the RSS COLA disregard, Medicaid need standards, special income level, assisted living maintenance needs allowance, special individual maintenance needs allowance, spousal impoverishment standards, MBIWD resource limit, MPAP resource limit, and the student child earned income exclusion. Medicare Part B premiums will not increase for 2014.

Note: It is anticipated that in 2014, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards. Information regarding the necessary CDJFS activity for these changes will be provided in a future MEPL.

**Personal Needs Allowance**

Effective January 1, 2014, the PNA for an individual residing in a nursing facility increases to $45, plus up to an additional sixty-five dollars of gross earnings received as a result of employment, for a possible maximum PNA of $110.

For an individual residing in an ICF/IID, the PNA will remain at the current amount of $40, plus up to an additional sixty-five dollars of gross earnings received as a result of employment, for a possible maximum PNA of $105.

**State Minimum Wage**

The state minimum wage increases from $7.85 per hour to $7.95 per hour, effective January 1, 2014.

**Home Equity Limit**

The home equity limit will increase for 2014.

<table>
<thead>
<tr>
<th>HOME EQUITY LIMIT AMOUNTS</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum amount of equity an individual can have in a home</td>
<td>$533,000</td>
<td>$543,000</td>
</tr>
</tbody>
</table>

**Social Security and Railroad Retirement Benefits**

Social Security benefits and railroad retirement benefits will increase for 2014.

**SSI Increase**

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$710</td>
<td>$721</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>$1,066</td>
<td>$1,082</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

**RSS Individuals**

The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

<table>
<thead>
<tr>
<th>DISREGARD OF SSI COLA INCORPORATED</th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>

...
<table>
<thead>
<tr>
<th><strong>Benefit</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum single individual SSI benefit</strong></td>
<td>$710</td>
<td>$721</td>
</tr>
<tr>
<td><strong>Maximum couple SSI benefit</strong></td>
<td>$1,066</td>
<td>$1,082</td>
</tr>
</tbody>
</table>

### Medicare Premium

<table>
<thead>
<tr>
<th><strong>MEDICARE PART B PREMIUM</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$104.90</td>
<td>$104.90*</td>
</tr>
</tbody>
</table>

* A Medicare beneficiary whose modified adjusted gross income is greater than $85,000 (individual) or $170,000 (filing a joint tax return) is responsible for a larger portion of the cost of Part B coverage. Therefore, in addition to the standard premium such a beneficiary must pay an income-related monthly adjustment amount.

### Medicaid Need Standard for Individual/Couple in Own Household

<table>
<thead>
<tr>
<th><strong>MEDICAID NEED STANDARDS</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$622</td>
<td>$632</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$1,066</td>
<td>$1,082</td>
</tr>
</tbody>
</table>

### Medicaid Need Standard for Individual/Couple in Household of Another

<table>
<thead>
<tr>
<th><strong>MEDICAID NEED STANDARDS</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$415</td>
<td>$422</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$711</td>
<td>$722</td>
</tr>
</tbody>
</table>

### Special Income Level

<table>
<thead>
<tr>
<th><strong>SPECIAL INCOME LEVEL</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$2,130</td>
<td>$2,163</td>
</tr>
</tbody>
</table>

### Assisted Living Maintenance Needs Allowance

<table>
<thead>
<tr>
<th><strong>NEEDS ALLOWANCE</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$710</td>
<td>$721</td>
</tr>
</tbody>
</table>

### Special Individual Maintenance Needs Allowance

<table>
<thead>
<tr>
<th><strong>NEEDS ALLOWANCE</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1,385</td>
<td>$1,406</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards

<table>
<thead>
<tr>
<th><strong>IMPOVERISHMENT STANDARDS</strong></th>
<th><strong>2013</strong></th>
<th><strong>2014</strong></th>
</tr>
</thead>
</table>
Minimum community spouse resource allowance | $23,184 | $23,448  
Maximum community spouse resource allowance | $115,920 | $117,240  
Maximum monthly maintenance needs allowance (Cap) | $2,898 | $2,931  

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2014.

**MBIWD Resource Eligibility Limit**

<table>
<thead>
<tr>
<th>MBIWD RESOURCE ELIGIBILITY LIMIT</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$11,148</td>
<td>$11,281</td>
</tr>
</tbody>
</table>

**MPAP Resource Limit**

<table>
<thead>
<tr>
<th>MPAP RESOURCE LIMIT</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,080</td>
<td>$7,160</td>
</tr>
<tr>
<td>Couple</td>
<td>$10,620</td>
<td>$10,750</td>
</tr>
</tbody>
</table>

**Student Child Earned Income Exclusion**

<table>
<thead>
<tr>
<th>STUDENT EXCLUSION</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (per month)</td>
<td>$1,730</td>
<td>$1,750</td>
</tr>
<tr>
<td>Earned income exclusion (per year)</td>
<td>$6,960</td>
<td>$7,060</td>
</tr>
</tbody>
</table>

The student child earned income exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

**Long Term Care Facility (LTCF) Individuals**

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5160:1-3-24 and 5160:1-3-24.1.

After the mass change is run, ODM will issue report BON003-R002 as in past years; this report is a summary of all individuals by LTCF.

Because of the increase in patient liability, case workers must issue prior notice for adverse action by the adverse action cutoff date of December 13, 2013 in order to avoid an error. If the adverse action notice is issued after the December 13 cutoff, then the increase cannot be effective until February 1, 2014.

**CRIS-E**

CRIS-E performs a mass change beginning November 28, 2013 to update items listed in this MEPL effective January 1, 2014.

- CRIS-E will generate alerts to case workers regarding cases updated by the mass change.
- To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.
- The CDJFS must provide notice to individuals bypassed during mass change, in accordance with OAC 5101:6-2-04.
CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the last day of the month following the month that the publication of the revised annual federal poverty level is issued.

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

Table TWAG is updated to reflect the increased state minimum wage amount; this new figure should be used for income calculations as described in rules 5160:1-2-01.9 and 5160:1-5-30. Other increased amounts can be found on updated tables TAST, TEXM and TMEP.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 71 (Effective January 1, 2013)</td>
<td>MEPL 83 (Effective January 1, 2014)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 82 (Medicaid: Standard Utility Allowance Increase)

Medicaid Eligibility Procedure Letter No. 82

September 19, 2013

Effective Date: October 1, 2013

To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Standard Utility Allowance Increase

Reason for Change: The Office of Family Assistance, with approval from the Food and Nutrition Service, is increasing the standard utility allowance (SUA) from $456 to $463. As a result of the increase in the Food Assistance Program's standard utility allowance, the SUA for determination of the minimum monthly maintenance needs allowance (MMMNA) is also being increased.

Ohio's SUA from the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the community spouse's MMMNA as part of the institutionalized spouse's patient liability calculation.

The MMMNA is used when determining the monthly income allowance (MIA) for a community spouse. The MIA, in turn, is deducted during the calculation of the institutionalized spouse's patient liability in order to account for the needs of the community spouse. The MIA is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2013) standard as well as the increased amount for 2014 (in bold).

<table>
<thead>
<tr>
<th>Standard Utility Allowance (SUA)</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$456</td>
<td>$463</td>
</tr>
</tbody>
</table>

Action Required: For budgets effective on or after October 1, 2013, the standard utility allowance of $463 shall be used when determining the community spouse's MIA.

A review of all long term care facility (LTCF) and home and community-based services (HCBS) covered groups with a community spouse must be completed prior to the October 1, 2013 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance.

These cases, with MIA for the community spouse (MA M), can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All covered groups affected by the increased utility allowance shall be provided with written notice of proposed action.

Effective October 1, 2013, all new applicants must have eligibility determined using the utility standard of $463.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new standard utility allowance can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 70 (Effective 1/1/13)</td>
<td>MEPL 82 (Effective 10/1/13)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:
ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/
InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 79 (Medicaid: 2013 MMMNA and ESA Standards)

Medicaid Eligibility Procedure Letter No. 79

June 20, 2013

Effective Date: July 1, 2013


To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2013 Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason for Change: Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines, per federal requirements established in 42 U.S.C. 1396r-5(d)(3)(A).

The Department of Health and Human Services provided the updated FPL guidelines in January, 2013, making July 1, 2013, the effective date for the new MMMNA and ESA standards.

Policy: The following Medicaid standards are affected by the increase in the FPL. This table shows the 2012 standard and the 2013 standard in bold.

<table>
<thead>
<tr>
<th>Standard</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMMNA Standard</td>
<td>$1,892</td>
<td>$1,939</td>
</tr>
<tr>
<td>ESA Standard</td>
<td>$ 568</td>
<td>$ 582</td>
</tr>
</tbody>
</table>

Action Required: No case alerts will be issued and there will not be a mass change completed by CRIS-E. Therefore, a manual review of all long term care facility and home & community based services assistance groups with a community spouse will need to be completed. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. The standards can also be found on CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 72 (Effective January 1, 2013)</td>
<td>MEPL No. 79 (Effective July 1, 2013)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 78 (Medicaid: ABD Deeming Calculator Update - 2013 Federal Poverty Levels)

Medicaid Eligibility Procedure Letter No. 78

February 19, 2013

Effective Date: March 1, 2013


To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: ABD Deeming Calculator Update - 2013 Federal Poverty Levels

Reason for Change: On January 24, 2013, the United States Department of Health and Human Services updated federal poverty level (FPL) income guidelines.

New Policy: The ABD deeming calculator has been updated with the 2013 federal poverty level income guidelines for the Medicare Premium Assistance Programs (MPAP): Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid.

The new federal poverty level guidelines will be effective beginning with the March 2013 budget month.

Action Required: Use the newest version of the ABD deeming calculator, found on the County Resources website, when performing budget calculations for ABD deeming cases where the applicant is also applying for any MPAP program.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 64</td>
<td>MEPL 77</td>
</tr>
<tr>
<td></td>
<td>(Effective March 1, 2012)</td>
<td>(Effective March 1, 2013)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 64 is obsolete upon the effective date of this MEPL.

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 77 (Medicaid: 2013 Federal Poverty Level Income Guidelines for MBIWD)

Medicaid Eligibility Procedure Letter No. 77

February 27, 2013

Effective Date: March 1, 2013

OAC Rules: 5101:1-41-30

To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2013 Federal Poverty Level Income Guidelines for Medicaid Buy-In for Workers with Disabilities (MBIWD)

Reason for Change: On January 24, 2013, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guideline for the MBIWD program has changed effective January 1, 2013.

Actions Required: Beginning January 1, 2013, the CDJFS must determine initial and ongoing eligibility for the MBIWD individual using the updated 250% FPL income guideline below:

<table>
<thead>
<tr>
<th>MBIWD 2013 Monthly FPL Income Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Income Guideline 250%</td>
</tr>
<tr>
<td>$2,394</td>
</tr>
</tbody>
</table>

Beginning January 1, 2013, the CDJFS must determine MBIWD premiums using the updated 150% and 450% FPL guidelines below:

<table>
<thead>
<tr>
<th>2013 Monthly FPL Income Guidelines for Premium Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

A mass change will not be run for MBIWD individuals. However, instructions on how to generate the necessary reports using the Business Information Channel (BIC) are available in the MEM in a desk aid entitled, "MBIWD FPL BIC Report Instructions." The data needed to generate this report will be available in BIC in the very near future.

For any cases identified as denied or terminated since January 1, 2013 using the previous year's FPL income guidelines, counties must redetermine eligibility using the updated FPL income guidelines, which are also found in table TMEP. To determine whether eligibility needs to be redetermined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go to step 2.
2. Review IQCT. If AEORE or AEABC was last run before February 8, 2013, re-run the case to redetermine eligibility.

For individuals who are already approved for MBIWD, the CDJFS is required to rerun the budgets, which includes recalculating the premium. When the CDJFS has determined that the updated premium is lower, the CDJFS must reduce the individual's premium obligation. However, if the updated premium is higher, the CDJFS shall not increase the premium until the MBIWD individual's annual redetermination.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 63 (Effective 1/1/12)</td>
<td>MEPL 77 (Effective March 1, 2013)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 63 is obsolete upon the effective date of this MEPL.

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
https://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
https://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
https://www.odjfs.state.oh.us/lpc/calendar/
MEPL 76 (Medicaid: 2013 Federal Poverty Level Income Guidelines for Low-Income MPAP)

Medicaid Eligibility Procedure Letter No. 76

February 19, 2013

Effective Date: March 1, 2013


To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2013 Federal Poverty Level Income Guidelines for Low-Income Medicare Premium Assistance Programs (MPAP)

Reason for Change: On January 24, 2013, the United States Department of Health and Human Services updated federal poverty level (FPL) income guidelines.

New Policy: Federal poverty level income guidelines for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective March 1, 2013.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRISE in table TMEP. The increased amounts for 2013 are in bold print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% FPL</td>
<td>$958</td>
<td>$1,293</td>
</tr>
<tr>
<td></td>
<td>$931 (2012)</td>
<td>$1,261 (2012)</td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary (SLMB) 120% FPL</td>
<td>$1,149</td>
<td>$1,551</td>
</tr>
<tr>
<td></td>
<td>$1,117 (2012)</td>
<td>$1,513 (2012)</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% FPL</td>
<td>$1,293</td>
<td>$1,745</td>
</tr>
<tr>
<td></td>
<td>$1,257 (2012)</td>
<td>$1,703 (2012)</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI) 200% FPL</td>
<td>$1,915</td>
<td>$2,585</td>
</tr>
<tr>
<td></td>
<td>$1,862 (2012)</td>
<td>$2,522 (2012)</td>
</tr>
</tbody>
</table>

Action Required: Table TMEP will be updated before CRISE’s adverse action cut off for March budgets. The change will automatically recalculate budgets on authorized cases. For cases where the mass change was not completed, the system generates alert #372 instructing the case worker to rerun the budgets. Counties must rerun these cases to update the cost-of-living adjustment (COLA) increases.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 62</td>
<td>MEPL 76</td>
</tr>
<tr>
<td></td>
<td>(Effective March 1, 2012)</td>
<td>(Effective March 1, 2013)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 62 is obsolete upon the effective date of this MEPL.
This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 75 (Medicaid: 2013 Federal Poverty Level Income Guidelines for Healthy Families and Healthy Start)

Medicaid Eligibility Procedure Letter No. 75

February 19, 2013

Effective Date: January 1, 2013


To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2013 Federal Poverty Level Income Guidelines for Healthy Families and Healthy Start

Reason for Change: On January 24, 2013, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guidelines for Healthy Start and Healthy Families programs have changed effective January 1, 2013.

Action Required: Beginning January 1, 2013, the CDJFS must determine initial and ongoing eligibility for Healthy Start and Healthy Families using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Families 90%</th>
<th>Healthy Start 150%*</th>
<th>Pregnant Women &amp; Healthy Start 200%**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$862</td>
<td>$1,437</td>
<td>$1,915</td>
</tr>
<tr>
<td>2</td>
<td>$1,164</td>
<td>$1,939</td>
<td>$2,585</td>
</tr>
<tr>
<td>3</td>
<td>$1,465</td>
<td>$2,442</td>
<td>$3,255</td>
</tr>
<tr>
<td>4</td>
<td>$1,767</td>
<td>$2,944</td>
<td>$3,925</td>
</tr>
<tr>
<td>5</td>
<td>$2,068</td>
<td>$3,447</td>
<td>$4,595</td>
</tr>
<tr>
<td>6</td>
<td>$2,370</td>
<td>$3,949</td>
<td>$5,265</td>
</tr>
</tbody>
</table>

*This standard is used for children with creditable insurance.

**This standard is used for children without creditable insurance.

A mass change will not be run for these individuals. However, the Healthy Families/Healthy Start/Transitional Medical Assistance Closure Report is available in the Business Information Channel (BIC). A desk aid called "CFC FPL BIC Report Instructions" in the Medicaid Eligibility Manual (MEM) describes how to generate the closure report. The data needed to generate this report will be available in BIC in the very near future.

For any cases identified as denied or terminated using the previous year’s FPL income guidelines, counties must redetermine eligibility using the new FPL income guidelines contained in table THST. To determine whether eligibility needs to be redetermined in a case listed on the closure report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go on to step 2.

2. Review IQCT: If AEORE or AEABC was last run before February 8, 2013, re-run the case to redetermine eligibility.
A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table THST.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 61 (Effective January 1, 2012)</td>
<td>MEPL 75 (Effective January 1, 2013)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 61 is obsolete upon the effective date of this MEPL. This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 74 (Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities)

Medicaid Eligibility Procedure Letter No. 74

February 12, 2013

Effective Date: February 1, 2013


To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities

Reason for Change: The Ohio Department of Aging has provided an updated average private pay rate for nursing facilities. The new rate is effective February 1, 2013.

Prior Policy: The previous average private pay rate, last updated in 2009, was $6,023.

New Policy: The updated private pay rate for nursing facilities is $6,114.

Action Required: A new period of restricted coverage is not computed for individuals currently in a penalty period. The CDJFS is not required to re-compute an improper transfer penalty period unless there is new information regarding the improper transfer (e.g. the resource was returned to the individual). The original notice that was issued to the consumer is still valid.

For new periods of restricted coverage calculated on or after February 1, 2013, the CDJFS is required to use the updated average private pay rate to calculate the penalty period.

CRIS-E reference table TMEP has been updated to reflect this increase for recurring budgets effective February 1, 2013.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 36 (effective 7/1/09)</td>
<td>MEPL 74 (effective 2/1/13)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
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**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 72 (Medicaid: 2012 MMMNA and ESA Standards)

Medicaid Eligibility Procedure Letter No. 72

November 30, 2012

Effective Date: January 1, 2013


To: Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director

Subject: Medicaid: 2012 Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason:

Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines per federal requirements established in 42 U.S.C. 1396r-5(d)(3)(A).

The Department of Health and Human Services provided the updated FPL guidelines in January, 2012, making July 1, 2012, the effective date for the new MMMNA and ESA standards.

New Policy:

In accordance with the above reason for change, the following Medicaid income standards are affected by the increase in the FPL. This table shows the 2011 standard and the 2012 standard in bold.

Policy:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,838</td>
<td>$1,892</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excess Shelter Allowance (ESA) Standard</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>$551</td>
<td>$568</td>
<td></td>
</tr>
</tbody>
</table>

Action Required:

No case alerts will be issued and there will not be a mass change completed by CRIS-E. Therefore, a desk review of all long term care facility and home & community based services assistance groups with a community spouse will need to be completed to apply the increased MMMNA and ESA standards retroactively back to July 1, 2012. These cases (MA M) can be identified by utilizing the caseload query system available on CRIS-E. The standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 55 (Effective July 1, 2011)</td>
<td>MEPL No. 72 (Effective January 1, 2013)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
Effective Date: January 1, 2013


To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Subject: 2013 Social Security Cost of Living Adjustment (COLA)

Reason for Change: ODJFS is required to make annual COLA adjustments based on the Consumer Price Index (CPI) to Social Security income, SSI, railroad retirement benefits, the RSS disregard, Medicare Part B premium, the home equity value limit, spousal impoverishment standards, Medicaid need standards, special income level, assisted living maintenance needs allowance, special maintenance needs allowance, MBIWD resource eligibility limit, MPAP resource limit and changes in the student child earned income exclusion.

Also, the Ohio Department of Commerce Division of Industrial Compliance and Labor increases the state minimum wage annually.

The tables in this MEPL include the 2012 limits, standards, benefits, and/or payment amounts for reference, along with the amounts for 2013 in bold.

Social Security and railroad retirement benefits will increase by 1.7% January 1, 2013. The 2013 COLA increase for Social Security and railroad retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals until February 28, 2013. For QMB or SLMB individuals, the COLA is only disregarded for the QMB
or SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individual’s Social Security benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 1.7% COLA.

In 2013, there will also be increases in the home equity limit, the RSS COLA disregard, Medicare Part B premiums, Medicaid need standards, special income level, assisted living maintenance needs allowance, special individual maintenance needs allowance, spousal impoverishment standards, MBIWD resource limit, MPAP resource limit, and the student child earned income exclusion.

Note: It is anticipated that in 2013, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards. Information regarding the necessary CDJFS activity for these changes will be provided in another MEPL.

State Minimum Wage
The state minimum wage increases from $7.70 per hour to $7.85 per hour, effective January 1, 2013.

Home Equity Limit
The home equity limit will increase for 2013.

<table>
<thead>
<tr>
<th>HOME EQUITY LIMIT AMOUNTS</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum amount of equity an individual can have in a home</td>
<td>$524,000</td>
<td>$533,000</td>
</tr>
</tbody>
</table>

Social Security and Railroad Retirement Benefits
Social Security benefits and railroad retirement benefits will increase for 2013.

SSI Increase

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$698</td>
<td>$710</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>$1,048</td>
<td>$1,066</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

RSS Individuals
The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

<table>
<thead>
<tr>
<th>DISREGARD OF SSI COLA INCREASE</th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>

Medicare Premium

<table>
<thead>
<tr>
<th>MEDICARE PART B PREMIUM</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$99.90</td>
<td>$104.90*</td>
</tr>
</tbody>
</table>
A Medicare beneficiary whose modified adjusted gross income is greater than $85,000 (individual) or $170,000 (filing a joint tax return) is responsible for a larger portion of the cost of Part B coverage. Therefore, in addition to the standard premium such a beneficiary must pay an income-related monthly adjustment amount.

### Medicaid Need Standard for Individual/Couple in Own Household

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$611</td>
<td>$622</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$1,048</td>
<td>$1,066</td>
</tr>
</tbody>
</table>

### Medicaid Need Standard for Individual/Couple in Household of Another

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$408</td>
<td>$415</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$699</td>
<td>$711</td>
</tr>
</tbody>
</table>

### Special Income Level

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$2,094</td>
<td>$2,130</td>
</tr>
</tbody>
</table>

### Assisted Living Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$698</td>
<td>$710</td>
</tr>
</tbody>
</table>

### Special Individual Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1,362</td>
<td>$1,385</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards

<table>
<thead>
<tr>
<th>IMPOVERISHMENT STANDARDS</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$22,728</td>
<td>$23,184</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$113,640</td>
<td>$115,920</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,841</td>
<td>$2,898</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2013.

### MBIWD Resource Eligibility Limit

<table>
<thead>
<tr>
<th>MBIWD RESOURCE ELIGIBILITY LIMIT</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
</table>
**MPAP Resource Limit**

<table>
<thead>
<tr>
<th>MPAP RESOURCE LIMIT</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$6,940</td>
<td>$7,080</td>
</tr>
<tr>
<td>Couple</td>
<td>$10,410</td>
<td>$10,620</td>
</tr>
</tbody>
</table>

**Student Child Earned Income Exclusion**

<table>
<thead>
<tr>
<th>STUDENT EXCLUSION</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (per month)</td>
<td>$1,700</td>
<td>$1,730</td>
</tr>
<tr>
<td>Earned income exclusion (per year)</td>
<td>$6,840</td>
<td>$6,960</td>
</tr>
</tbody>
</table>

The student child earned income exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

**Long Term Care Facility (LTCF) Individuals**

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5101:1-39-24 and 5101:1-39-24.1.

After the mass change is run, ODJFS will issue report BON003-R002, which is a summary of all individuals by LTCF.

Because of the increase in patient liability, case workers must issue prior notice for adverse action by the adverse action cutoff date of December 13, 2012 in order to avoid an error. If the adverse action notice is issued after the December 13 cutoff, then the increase cannot be effective until February 1, 2013.

**CRIS-E**

CRIS-E performs a mass change beginning November 22, 2012 to update items listed in this MEPL effective January 1, 2013.

- CRIS-E will generate alerts to case workers regarding cases updated by the mass change.
- To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.
- The CDJFS must provide notice to individuals bypassed during mass change, in accordance with OAC 5101:6-2-04.
- CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the last day of the month following the month that the publication of the revised annual federal poverty level is issued.

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

**Other Action Required**: No desk review is required by county workers. Table TWAG is updated to reflect the increased state minimum wage amount. This new figure should be used for income calculations as described in rules 5101:1-38-01.9 and 5101:1-41-30 of the Administrative Code.

**MEM Instructions:**
This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

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http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 70 (Medicaid: Standard Utility Allowance Decrease)

Medicaid Eligibility Procedure Letter No. 70

November 30, 2012

Effective Date: January 1, 2013


To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director
Office of Medical Assistance

Subject: Medicaid: Standard Utility Allowance Decrease

Reason for Change:
Ohio's standard utility allowance (SUA) in the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. The Food Assistance Program uses data from the Public Utilities Commission of Ohio and local utility companies to establish statewide averages for the SUA. The data reflected changes to the regulation of gas prices and attributed to the decrease in the SUA beginning January 1, 2013. The Food Assistance program's request to the Food and Nutritional Services to grant a waiver for decreasing the SUA was approved. As a result of the decrease in the Food Assistance Program utility standard from $533 to $456, the standard utility allowance for determination of the MMMNA is also being decreased.

The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The MIA is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2012) standard as well as the decreased amount for 2013 (in bold).

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Utility Allowance (SUA)</td>
<td>$533</td>
</tr>
</tbody>
</table>

Action Required:
For budgets effective on or after January 1, 2013, the standard utility allowance of $456 shall be used when determining the community spouse's MIA.

A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed between November 21 (when the table is updated) and December 14 (the adverse action deadline for January 1 budgets) to ensure the new decreased standard is applied appropriately. The CDJFS must recalculate the MIA using the decreased utility allowance.

These cases, MIA for the community spouse (MA M), can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All assistance groups affected by the decreased utility allowance shall be provided with written notice of proposed action.

Effective January 1, 2013, all new applicants must have eligibility determined using the utility standard of $456.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new standard utility allowance can be found in CRIS-E reference table Medicaid Eligibility Parameter (TMEP).

MEM Instructions:
<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 67</td>
<td>MEPL 70</td>
</tr>
<tr>
<td></td>
<td>(Effective 10/1/2012)</td>
<td>(Effective 1/1/2013)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**

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http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 69 (Medicaid: State Mileage Rate Decrease)
Medicaid Eligibility Procedure Letter No. 69

December 3, 2012

Effective Date: January 1, 2013


To: All Medicaid Eligibility Manual Holders

From: John B. McCarthy, Director
Office of Medical Assistance

Subject: Medicaid: State Mileage Rate Decrease

Reason for Change: The Ohio Office of Budget and Management decreased the state mileage rate from $.51 to $.45. Individuals may use the state mileage rate to reduce countable income for Medicaid.

Prior Policy: The state mileage rate was $.51 prior to 1/1/13.

New Policy: Effective 1/1/13 the state mileage rate decreases to $.45 per mile.

Action Required: Individuals with self-employment deductions from mileage and consumers who utilize mileage expenses in their spend-down calculations are affected by this change. There is no desk review required

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
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<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 25 (effective 5/1/08)</td>
<td>MEPL No. 69 (effective 1/1/13)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjs.state.oh.us/lpc/calendar/
MEPL 67 (Medicaid: Standard Utility Allowance No Change)

Medicaid Eligibility Procedure Letter No. 67

September 27, 2012

Effective Date: October 1, 2012


To: All Medicaid Eligibility Manual Holders
From: John B. McCarthy, Director

Office of Medical Assistance

Subject: Medicaid: Standard Utility Allowance No Change

Reason for Change:

Ohio's standard utility allowance in the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of no change in the Food Assistance Program utility standard of $533, the standard utility allowance for determination of the MMMNA is also not changed.

The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (April 2012) standard as well as the amount for October 2012 (in bold).

<table>
<thead>
<tr>
<th></th>
<th>April 2012</th>
<th>October 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Utility Allowance (SUA)</td>
<td>$533</td>
<td>$533</td>
</tr>
</tbody>
</table>

Action Required:

For budgets effective on or after October 1, 2012, the standard utility allowance of $533 shall be used when determining the community spouse's monthly income allowance (MIA).

Effective October 1, 2012, all new applicants must have eligibility determined using the utility standard of $533.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The utility standard can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 60 (Effective 4/1/2012)</td>
<td>MEPL 67 (Effective 10/1/2012)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
MEPL 64 (ABD Deeming Calculator Update)

Medicaid Eligibility Procedure Letter No. 64

February 29, 2012

Effective Date: March 1, 2012


To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: ABD Deeming Calculator Update


New Policy: The ABD deeming calculator has been updated with the 2012 federal poverty level income guidelines for the Medicare Premium Assistance Programs (MPAP): Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid.

The new federal poverty level guidelines will be effective beginning with the March 2012 budget month.

Action Required: Use the newest version of the ABD deeming calculator, found on the County Resources website, when performing budget calculations for ABD deeming cases where the applicant is also applying for any MPAP program.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>N/A</td>
<td>MEPL 64</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective March 1, 2012)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 63 (Medicaid: 2012 Federal Poverty Level Income Guidelines for MBIWD)

Medicaid Eligibility Procedure Letter No. 63

February 24, 2012

Effective Date: January 1, 2012

OAC Rules: 5101:1-41-30

To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: 2012 Federal Poverty Level Income Guidelines for Medicaid Buy-In for Workers with Disabilities (MBIWD)

Reason for Change: On January 26, 2012, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guideline for the MBIWD program has changed effective January 1, 2012.

Actions Required: Beginning January 1, 2012, the CDJFS must determine initial and ongoing eligibility for the MBIWD individual using the updated 250% FPL income guideline below:

| Individual Income Guideline 250% | $2,328 |

Beginning January 1, 2012, the CDJFS must determine MBIWD premiums using the updated 150% and 450% FPL guidelines below:

<table>
<thead>
<tr>
<th>2012 Monthly FPL Income Guidelines for Premium Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Size</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

For any cases identified as denied or terminated since January 1, 2012 using the previous year’s FPL income guidelines, counties must redetermine eligibility using the updated FPL income guidelines, which are also found in table TMEP. To determine whether eligibility needs to be redetermined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go to step 2.

2. Review IQCT. If AEORE or AEABC was last run before February 6, 2012, re-run the case to redetermine eligibility.

For individuals who are already approved for MBIWD, the CDJFS is required to rerun the budgets, which includes recalculating the premium. When the CDJFS has determined that the updated premium is lower, the
CDJFS must reduce the individual’s premium obligation. However, if the updated premium is higher, the CDJFS shall not increase the premium until the MBIWD individual’s annual redetermination.

A mass change will not be run for MBIWD individuals. However, instructions on how to generate the necessary reports using the Business Information Channel (BIC) are available in the MEM in a desk aid entitled, "MBIWD FPL BIC Report Instructions." The data needed to generate this report should be available in BIC beginning on February 15, 2012.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 53 (Effective 1/1/11)</td>
<td>MEPL 63 (Effective 1/1/12)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

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**Internet Calendar:**

http://www.odijs.state.oh.us/lpc/calendar/
MEPL 62 (Medicaid: 2012 Federal Poverty Level Income Guidelines for Low Income Medicare Premium Assistance Programs)

Medicaid Eligibility Procedure Letter No. 62

February 24, 2012

Effective Date: March 1, 2012


To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: 2012 Federal Poverty Level Income Guidelines for Low Income Medicare Premium Assistance Programs


New Policy: Federal poverty level income guidelines for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective March 1, 2012.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRISE in table TMEP. The increased amounts for 2012 are in bold print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% FPL</td>
<td>$931</td>
<td>$1,261</td>
</tr>
<tr>
<td></td>
<td>$908 (2011)</td>
<td>$1,226 (2011)</td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary</td>
<td>$1,117</td>
<td>$1,513</td>
</tr>
<tr>
<td>(SLMB) 120% FPL</td>
<td>$1,089 (2011)</td>
<td>$1,471 (2011)</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% FPL</td>
<td>$1,257</td>
<td>$1,703</td>
</tr>
<tr>
<td></td>
<td>$1,226 (2011)</td>
<td>$1,655 (2011)</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual</td>
<td>$1,862</td>
<td>$2,522</td>
</tr>
<tr>
<td>(QWDI) 200% FPL</td>
<td>$1,815 (2011)</td>
<td>$2,452 (2011)</td>
</tr>
</tbody>
</table>

Action Required: Table TMEP will be updated before CRISE’s adverse action cut off for March budgets. The change will automatically recalculate budgets on authorized cases. For cases where the mass change was not completed, the system generates an alert #372 instructing the case worker to rerun the budgets. Counties must rerun these cases to update the cost-of-living adjustment (COLA) increases.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
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<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 53</td>
<td>MEPL 62</td>
</tr>
<tr>
<td></td>
<td>(Effective March 1, 2011)</td>
<td>(Effective March 1, 2012)</td>
</tr>
</tbody>
</table>
MEPL 53 is obsolete upon the effective date of this MEPL.

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 61 (Medicaid: 2012 Federal Poverty Level Income Guidelines for Healthy Families and Healthy Start)

Medicaid Eligibility Procedure Letter No. 61

February 29, 2012

Effective Date: January 1, 2012


To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: 2012 Federal Poverty Level Income Guidelines for Healthy Families and Healthy Start

Reason for Change: On January 26, 2012, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guidelines for Healthy Start and Healthy Families programs have changed effective January 1, 2012.

Action Required: Beginning January 1, 2012, the CDJFS must determine initial and ongoing eligibility for Healthy Start and Healthy Families using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Families 90%</th>
<th>Healthy Start 150%*</th>
<th>Pregnant Women &amp; Healthy Start 200%**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$838</td>
<td>$1,397</td>
<td>$1,862</td>
</tr>
<tr>
<td>2</td>
<td>$1,135</td>
<td>$1,892</td>
<td>$2,522</td>
</tr>
<tr>
<td>3</td>
<td>$1,432</td>
<td>$2,387</td>
<td>$3,182</td>
</tr>
<tr>
<td>4</td>
<td>$1,729</td>
<td>$2,882</td>
<td>$3,842</td>
</tr>
<tr>
<td>5</td>
<td>$2,026</td>
<td>$3,377</td>
<td>$4,502</td>
</tr>
<tr>
<td>6</td>
<td>$2,323</td>
<td>$3,872</td>
<td>$5,162</td>
</tr>
</tbody>
</table>

*This standard is used for children with creditable insurance.

**This standard is used for children without creditable insurance.

A mass change will not be run for these individuals. However, a desk aid called "CFC FPL BIC Report Instructions" is available in the Medicaid Eligibility Manual (MEM) describing how to generate the Healthy Families/Healthy Start/Transitional Medical Assistance Closure Report using the Business Information Channel. The data needed to generate this report should be available in BIC beginning on February 15, 2012.

For any cases identified as denied or terminated using the previous year’s FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in table THST. To determine whether eligibility needs to be determined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go on to step 2.
2. Review IQCT - If AEORE or AEABC was last run before February 6, 2012, re-run the case to redetermine eligibility.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table THST.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 53</td>
<td>MEPL 61</td>
</tr>
<tr>
<td></td>
<td>(Effective Jan 1, 2011)</td>
<td>(Effective Jan 1, 2012)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 53 is obsolete upon the effective date of this MEPL.

This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals:**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 60 (Medicaid: Standard Utility Allowance Decrease)

Medicaid Eligibility Procedure Letter No. 60

February 17, 2012

Effective Date: April 1, 2012


To: All Medicaid Eligibility Manual Holders
From: Michael B. Colbert, Director
Subject: Medicaid: Standard Utility Allowance Decrease

Reason for Change:
Ohio's standard utility allowance in the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the decrease in the Food Assistance Program utility standard from $599 to $533, the standard utility allowance for determination of the MMMNA is also being decreased.

The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2011) standard as well as the decreased amount for 2012 (in bold).

<table>
<thead>
<tr>
<th>Standard Utility Allowance (SUA)</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$599</td>
<td>$533</td>
</tr>
</tbody>
</table>

Action Required:
For budgets effective on or after April 1, 2012, the standard utility allowance of $533 shall be used when determining the community spouse's monthly income allowance (MIA).

A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the April 1, 2012 cutoff to ensure the new decreased standard is applied appropriately. The CDJFS must recalculate the MIA using the decreased utility allowance.

These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All assistance groups affected by the decreased utility allowance shall be provided with written notice of proposed action.

Effective April 1, 2012, all new applicants must have eligibility determined using the utility standard of $533.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 57 (Effective 10/1/2011)</td>
<td>MEPL 60 (Effective 4/1/2012)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 59 (Medicaid: January 2012 COLA Mass Change)

Medicaid Eligibility Procedure Letter No. 59

December 7, 2011

Effective Date: January 1, 2012

ODJFS is required to make annual adjustments based on the Consumer Price Index (CPI) to the home equity value limit and the Social Security cost-of-living adjustment (COLA) for SSI, railroad retirement benefits, the RSS disregard, Medicare Part B premium, spousal impoverishment standards, Medicaid need standards, special income level, assisted living maintenance needs allowance, special maintenance needs allowance, MBIWD resource eligibility limit, MPAP resource limit and changes in the student child earned income exclusion.

Reason for Change: The Ohio Department of Commerce Division of Industrial Compliance and Labor increases the state minimum wage to $7.70 per hour, effective January 1, 2012.

Prior Policy: The previous state minimum wage was $7.40 per hour.

The tables in this MEPL include the 2011 limits, standards, benefits, and/or payment amounts along with the amounts for 2012 in bold.
New Policy: The state minimum wage is $7.70 per hour, effective January 1, 2012.

Social Security and railroad retirement benefits will increase by 3.6% January 1, 2012. The 2012 COLA increase for Social Security and railroad retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals until February 29, 2012. For QMB or SLMB individuals, the COLA is only disregarded for the QMB or SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individual's Social Security benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 3.6% COLA.

In 2012, there will also be increases in the home equity limit, the RSS COLA disregard, Medicare Part B premiums, Medicaid need standards, special income level, assisted living maintenance needs allowance, special individual maintenance needs allowance, spousal impoverishment standards, MBIWD resource limit, MPAP resource limit, and the student child earned income exclusion.

Note: It is anticipated that in 2012, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards. Information regarding the necessary CDJFS activity for these changes will be provided in another MEPL.

Home Equity Limit
The home equity limit will increase for 2012.

<table>
<thead>
<tr>
<th>HOME EQUITY LIMIT AMOUNTS</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum amount of equity an individual can have in a home</td>
<td>$506,000</td>
<td>$524,000</td>
</tr>
</tbody>
</table>

Social Security and Railroad Retirement Benefits
Social Security benefits and railroad retirement benefits will increase for 2012.

SSI Increase

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$674</td>
<td>$698</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>$1,011</td>
<td>$1,048</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

RSS Individuals
The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

<table>
<thead>
<tr>
<th>DISREGARD OF SSI COLA INCREASE</th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum single individual SSI benefit</td>
<td>2011</td>
<td>$674</td>
<td>2012</td>
</tr>
<tr>
<td>Maximum couple SSI benefit</td>
<td>2011</td>
<td>$1,011</td>
<td>2012</td>
</tr>
</tbody>
</table>

Medicare Premium
MEDICAID PART B PREMIUM

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2011</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare B Premium</td>
<td>$96.40</td>
<td>$110.50†</td>
<td>$115.40††</td>
<td>$99.90*</td>
</tr>
</tbody>
</table>

* A Medicare beneficiary whose modified adjusted gross income is greater than $85,000 (individual) or $170,000 (filing a joint tax return) is responsible for a larger portion of the cost of Part B coverage. Therefore, in addition to the standard premium such a beneficiary must pay an income-related monthly adjustment amount.

† Note: This Medicare premium applied in 2010 and 2011 to individuals who became entitled to Social Security Aged, Blind, or Disabled benefits after November 2009 thru October 2010 due to late or new enrollment.

† † Note: This Medicare premium applied in 2011 to individuals who became entitled to Social Security Aged, Blind, or Disabled benefits after November 2010 due to late or new enrollment.

**Medicaid Need Standard for Individual/Couple in Own Household**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$589</td>
<td>$611</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$1,011</td>
<td>$1,048</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Household of Another**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$393</td>
<td>$408</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$674</td>
<td>$699</td>
</tr>
</tbody>
</table>

**Special Income Level**

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$2,022</td>
<td>$2,094</td>
</tr>
</tbody>
</table>

**Assisted Living Maintenance Needs Allowance**

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$674</td>
<td>$698</td>
</tr>
</tbody>
</table>

**Special Individual Maintenance Needs Allowance**

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
</table>
Special individual maintenance needs allowance used to determine HCBS waiver patient liability | 2011 | 2012 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,315</td>
<td>$1,362</td>
<td></td>
</tr>
</tbody>
</table>

**Spousal Impoverishment Standards**

<table>
<thead>
<tr>
<th>IMPOVERISHMENT STANDARDS</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$21,912</td>
<td>$22,728</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$109,560</td>
<td>$113,640</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,739</td>
<td>$2,841</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2012, when the federal poverty level is updated.

**MBIWD Resource Eligibility Limit**

<table>
<thead>
<tr>
<th>MBIWD RESOURCE ELIGIBILITY LIMIT</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$10,580</td>
<td>$10,961</td>
</tr>
</tbody>
</table>

**MPAP Resource Limit**

<table>
<thead>
<tr>
<th>MPAP RESOURCE LIMIT</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$6,680</td>
<td>$6,940</td>
</tr>
<tr>
<td>Couple</td>
<td>$10,020</td>
<td>$10,410</td>
</tr>
</tbody>
</table>

**Student Child Earned Income Exclusion**

<table>
<thead>
<tr>
<th>STUDENT EXCLUSION</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (up to)</td>
<td>$1,640</td>
<td>$1,700</td>
</tr>
<tr>
<td>Earned income exclusion (no more than)</td>
<td>$6,600</td>
<td>$6,840</td>
</tr>
</tbody>
</table>

The student child earned income exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

**Long Term Care Facility (LTCF) Individuals**

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5101:1-39-24 and 5101:1-39-24.1.
After the mass change is run, ODJFS will issue report BON003-R002, which is a summary of all individuals by LTCF.

Because of the increase in patient liability, case workers must issue prior notice for adverse action before December 15, 2011. If the adverse action notice is issued after December 15, then the increase cannot be effective until February 1, 2012 in order to avoid an error.

**CRIS-E**

CRIS-E performs a mass change beginning November 27, 2008 to update items listed in this MEPL effective January 1, 2009.

- CRIS-E will generate alerts to case workers regarding cases updated by the mass change.
- To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.
- The CDJFS must provide notice to individuals bypassed during mass change, in accordance with OAC 5101:6-2-04.
- CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the last day of the month following the month that the publication of the revised annual federal poverty level is issued.

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

**Other Action Required:** No desk review is required by county workers. Table TWAG is updated to reflect the increased state minimum wage amount. This new figure should be used for income calculations as described in rules 5101:1-40-20.1 and 5101:1-41-30 of the Administrative Code.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
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</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 52 (Effective January 1, 2011)</td>
</tr>
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</table>

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 57 (Medicaid: Standard Utility Allowance No Change)

Medicaid Eligibility Procedure Letter No. 57

September 20, 2011

Effective Date: October 1, 2011


To: All Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: Standard Utility Allowance No Change

Reason for Change:

Ohio’s standard utility allowance in the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of no change in the Food Assistance Program utility standard of $599, the standard utility allowance for determination of the MMMNA is also not changed.

The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2010) standard as well as the amount for 2011 (in bold).

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Utility Allowance (SUA)</td>
<td>$599</td>
<td>$599</td>
</tr>
</tbody>
</table>

Action Required:

For budgets effective on or after October 1, 2011, the standard utility allowance of $599 shall be used when determining the community spouse's monthly income allowance (MIA).

Effective October 1, 2011, all new applicants must have eligibility determined using the utility standard of $599.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
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<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 50 (Effective 10/1/2010)</td>
<td>MEPL 57 (Effective 10/1/2011)</td>
</tr>
</tbody>
</table>

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**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 55 (Medicaid: 2011 MMMNA and ESA Standards)

Medicaid Eligibility Procedure Letter No. 55

June 23, 2011

Effective Date: July 1, 2011


To: Medicaid Eligibility Manual Holders

From: Michael B. Colbert, Director

Subject: Medicaid: 2011 Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason:

Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines per federal requirements established in 42 U.S.C. 1396r-5(d)(3)(A).

The Department of Health and Human Services provided the updated FPL guidelines in January, 2011, making July 1, 2011, the effective date for the new MMMNA and ESA standards.

New Policy:

In accordance with the above reason for change, the following Medicaid income standards are affected by the increase in the FPL. This table shows the 2010 standard and the 2011 standard in bold.

Policy:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess Shelter Allowance (ESA) Standard</td>
<td>$546</td>
<td>$551</td>
</tr>
</tbody>
</table>

Action Required:

No case alerts will be issued and there will not be a mass change completed by CRIS-E. Therefore, a manual review of all long term care facility and home & community based services assistance groups with a community spouse will need to be completed. The standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

Medicaid Eligibility Policy Letters

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 48 (Effective July 1, 2010)</td>
<td>MEPL No. 55 (Effective July 1, 2011)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjs.state.oh.us/lpc/calendar/staff/
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 53 (Medicaid: 2011 Federal Poverty Level Income Guidelines for Medicaid Programs)

Medicaid Eligibility Procedure Letter No. 53

February 1, 2011

Effective Date:  January 1, 2011


To:  All Medicaid Eligibility Manual Holders

From:  Michael B. Colbert, Interim Director

Subject:  Medicaid: 2011 Federal Poverty Level Income Guidelines for Medicaid Programs

Reason for Change:  On January 20, 2011, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy:  The FPL income guidelines for Medicaid programs have changed effective January 1, 2011.

Action Required:  Beginning January 1, 2011, the CDJFS must determine initial and ongoing eligibility for Medicaid using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Families 90%</th>
<th>Healthy Start 150%</th>
<th>Transitional 185%</th>
<th>Pregnant Women &amp; Healthy Start 200%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$817</td>
<td>$1,362</td>
<td>$1,679</td>
<td>$1,815</td>
</tr>
<tr>
<td>2</td>
<td>$1,104</td>
<td>$1,839</td>
<td>$2,268</td>
<td>$2,452</td>
</tr>
<tr>
<td>3</td>
<td>$1,390</td>
<td>$2,317</td>
<td>$2,857</td>
<td>$3,089</td>
</tr>
<tr>
<td>4</td>
<td>$1,677</td>
<td>$2,794</td>
<td>$3,446</td>
<td>$3,725</td>
</tr>
<tr>
<td>5</td>
<td>$1,963</td>
<td>$3,272</td>
<td>$4,035</td>
<td>$4,362</td>
</tr>
<tr>
<td>6</td>
<td>$2,250</td>
<td>$3,749</td>
<td>$4,624</td>
<td>$4,999</td>
</tr>
</tbody>
</table>

*This standard is used for children when no creditable insurance exists.

<table>
<thead>
<tr>
<th>MBIWD 2011 Monthly FPL Income Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Income Guideline 250%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2011 Monthly FPL Income Guidelines for Premium Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

### 2011 Medicare Premium Assistance Program

#### FPL Guidelines*

<table>
<thead>
<tr>
<th>Status</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% FPL</td>
<td>$908</td>
<td>$1,226</td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary (SLMB) 120% FPL</td>
<td>$1,089</td>
<td>$1,471</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% FPL</td>
<td>$1,226</td>
<td>$1,655</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI) 200% FPL</td>
<td>$1,815</td>
<td>$2,452</td>
</tr>
</tbody>
</table>

*Because there was no cost-of-living adjustment increase for individuals receiving Social Security benefits (i.e., no adverse action period), the effective date of this change is effective January 1, 2011.

A mass change will not be run for any individuals affected by the federal poverty level increase. However, for any cases identified as denied or terminated using the previous year's FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in CRISE tables THST and TMEP.

For individuals who are already approved for MBIWD, the CDJFS is required to rerun the budgets, which includes redetermining the premium. When the CDJFS has determined the updated premium is lower, the CDJFS must reduce the individual's premium obligation. However, the CDJFS shall not increase the premium of any MBIWD individual until the annual redetermination.

In order to identify denied cases for January 2011, CDJFS staff will need to have access to the Business Intelligence Channel (BIC), found on the ODJFS innerweb at http://innerweb.odjfs.state.oh.us/omis/biss/bic/index.shtml. Instructions for accessing BIC will be found there.

Two desk aids, called "CFC/MPAP FPL BIC Report Instructions" and "MBIWD FPL BIC Report Instructions", are available in the Medicaid Eligibility Manual (MEM) describing how to generate CFC/MPAP and MBIWD medical assistance closure reports using the BIC. The data needed to generate this report should be available in BIC beginning on February 14, 2011. To determine whether eligibility needs to be determined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go on to step 2.
2. Review IQCT - If AEORE or AEABC was last run on or before January 20, 2011, re-run the case to redetermine eligibility.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference tables THST and TMEP.

### MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 31 (Effective January 1, 2009)</td>
<td>MEPL 53 (Effective January 1, 2011)</td>
</tr>
<tr>
<td></td>
<td>MEPL 32 (Effective January 1, 2009)</td>
<td></td>
</tr>
</tbody>
</table>
Medicaid Eligibility Policy Letter Nos. 31, 32, 33 are obsolete upon the effective date of this MEPL. This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals:**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/

**Business Intelligence Channel:**
http://innerweb.odjfs.state.oh.us/omis/biss/bic/index.shtml
MEPL 52 (Medicaid: 2011 COLA and State Minimum Wage Increase)

Medicaid Eligibility Procedure Letter No. 52

December 8, 2010

**Effective Date:** January 1, 2011


To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: State Minimum Wage Increase

Home Equity Value Increase

Consumer Price Index (CPI) Increase

2011 Social Security Cost of Living Adjustment (COLA)

Social Security Income (SSI) Benefit Increase

Railroad Retirement Benefit Increase

RSS COLA Disregard

Medicare Part B Premium Increase

Medicaid Need Standards Increase

Special Income Level (SIL) Increase

Assisted Living Maintenance Needs Allowance (ALMNA) Increase

Special Maintenance Needs Allowance (SMNA) Increase

Spousal Impoverishment Standards Increase

MBIWD Resource Eligibility Limit Increase

MPAP Resource Limit Increase

Student Child Earned Income Exclusion Increase

**Reason for Change:** The Ohio Department of Commerce Division of Industrial Compliance and Labor increases the state minimum wage to $7.40 per hour, effective January 1, 2011.

ODJFS is required to make annual adjustments based on the Consumer Price Index (CPI) to the home equity value limit and the Social Security cost-of-living adjustment (COLA) for SSI, railroad retirement benefits, the RSS disregard, Medicare Part B premium, spousal impoverishment standards, Medicaid need standards, special income level, assisted living maintenance needs allowance, special maintenance needs allowance, MBIWD resource eligibility limit, MPAP resource limit and changes in the student child earned income exclusion.

**Prior Policy:** The previous state minimum wage was $7.30 per hour.

The tables in this MEPL include the 2010 limits, standards, benefits, and/or payment amounts along with the amounts for 2011 in bold.
New Policy: The state minimum wage is $7.40 per hour, effective January 1, 2011.

The federal government determined there will be no COLA adjustment in 2011. Therefore, there will be no increase in Social Security benefits payable in 2011, nor will there be an increase in SSI payments for 2011. There will be an increase in the home equity limit. There will also be an increase for 2011 regarding Medicare Part B premiums and an increase for 2011 in the MPAP resource limit.

Home Equity Limit

The home equity limit will not increase for 2011.

<table>
<thead>
<tr>
<th>HOME EQUITY LIMIT AMOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Maximum amount of equity an individual can have in a home</td>
</tr>
</tbody>
</table>

Social Security and Railroad Retirement Benefits

Social Security benefits and railroad retirement benefits will not increase for 2011.

SSI Increase

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Single individual living independently</td>
</tr>
<tr>
<td>Couple living independently</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

RSS Individuals

Since there is no SSI COLA for 2011, the COLA disregard for the Residential State Supplement (RSS) program will remain the same as for 2010. The following chart provides the SSI COLA and the total amounts to be disregarded to date when determining financial eligibility and cash payments for RSS individuals.

<table>
<thead>
<tr>
<th>DISREGARD OF SSI COLA INCREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>$674</td>
</tr>
<tr>
<td>$1,011</td>
</tr>
</tbody>
</table>

Medicare Premium

<table>
<thead>
<tr>
<th>MEDICAID PART B PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
| Medicare Part B | $96.40 | $96.40* | $110.50* | $115.40* † †
A Medicare beneficiary whose modified adjusted gross income is greater than $85,000 (individual) or $170,000 (filing a joint tax return) is responsible for a larger portion of the cost of Part B coverage. Therefore, in addition to the standard premium (whether that is $96.40, $110.50, or $115.40 for the individual) such a beneficiary must pay an income-related monthly adjustment amount.

† Note: This increased Medicare premium applies to individuals who become entitled to Social Security Aged, Blind, or Disabled benefits after November 2009 thru October 2010 due to late or new enrollment.

† † Note: This increased Medicare premium applies to individuals who become entitled to Social Security Aged, Blind, or Disabled benefits after November 2010 due to late or new enrollment.

**Medicaid Need Standard for Individual/Couple in Own Household**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$589</td>
<td>$589</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$1,011</td>
<td>$1,011</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Household of Another**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$393</td>
<td>$393</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$674</td>
<td>$674</td>
</tr>
</tbody>
</table>

**Special Income Level**

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$2,022</td>
<td>$2,022</td>
</tr>
</tbody>
</table>

**Assisted Living Maintenance Needs Allowance**

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$674</td>
<td>$674</td>
</tr>
</tbody>
</table>

**Special Maintenance Needs Allowance**

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1,315</td>
<td>$1,315</td>
</tr>
</tbody>
</table>
Spousal Impoverishment Standards

<table>
<thead>
<tr>
<th>Imoeverishment Standards</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$21,912</td>
<td>$21,912</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$109,560</td>
<td>$109,560</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,739</td>
<td>$2,739</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2011, when the federal poverty level is updated.

MBIWD Resource Eligibility Limit

<table>
<thead>
<tr>
<th>MBIWD Resource Eligibility Limit</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$10,580</td>
<td>$10,580</td>
</tr>
</tbody>
</table>

MPAP Resource Limit

<table>
<thead>
<tr>
<th>MPAP Resource Limit</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$6,600</td>
<td>$6,680</td>
</tr>
<tr>
<td>Couple</td>
<td>$9,910</td>
<td>$10,020</td>
</tr>
</tbody>
</table>

Student Child Earned Income Exclusion

<table>
<thead>
<tr>
<th>Student Exclusion</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (up to)</td>
<td>$1,640</td>
<td>$1,640</td>
</tr>
<tr>
<td>Earned income exclusion (no more than)</td>
<td>$6,600</td>
<td>$6,600</td>
</tr>
</tbody>
</table>

The student child earned income exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

Long Term Care Facility (LTCF) Individuals

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5101:1-39-24 and 5101:1-39-24.1.

Action Required: No desk review is required by county workers. Table TWAG is updated to reflect the increased state minimum wage amount. This new figure should be used for income calculations as described in rules 5101:1-40-20.1 and 5101:1-41-30 of the Administrative Code.

Because there is no COLA for 2011, mass change will not be run. No reports, alerts, or notices shall be issued in CRIS-E. However, counties shall use the correct Medicare Part B premium on CRIS-E screen AEFMC when determining eligibility.
### MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
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<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 38 (Effective July 24, 2009)</td>
<td>MEPL 52 (Effective January 1, 2011)</td>
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<tr>
<td></td>
<td>MEPL 41 (Effective January 1, 2010)</td>
<td>MEPL 52 (Effective January 1, 2011)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 50 (Medicaid: Standard Utility Allowance Increase)
Medicaid Eligibility Procedure Letter No. 50

August 27, 2010

Effective Date: October 1, 2010
To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Standard Utility Allowance Increase

Reason for Change:
Ohio's standard utility allowance in the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the increase in the Food Assistance Program utility standard from $588 to $599, the standard utility allowance for determination of the MMMNA is also being increased.

The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2009) standard as well as the increased amount for 2010 (in bold).

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Utility Allowance (SUA)</td>
<td>$588</td>
<td>$599</td>
</tr>
</tbody>
</table>

Action Required:
For budgets effective on or after October 1, 2010, the standard utility allowance of $599 shall be used when determining the community spouse's monthly income allowance (MIA).

A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2010 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance.

These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All assistance groups affected by the increased utility allowance shall be provided with written notice of proposed action.

Effective October 1, 2010, all new applicants must have eligibility determined using the utility standard of $599.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found in CRIS-E reference table TMEP.

MEM Instructions:

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<tr>
<th>Location</th>
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<tr>
<td>MEPLs</td>
<td>MEPL 39 (Effective 10/1/2009)</td>
<td>MEPL 50 (Effective 10/1/2010)</td>
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</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 48 (Medicaid: 2010 Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards)

Medicaid Eligibility Procedure Letter No. 48

June 21, 2010

Effective Date: July 1, 2010


To: Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: 2010 Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason:

Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines per federal requirements established in 42 U.S.C. 1396r-5(d)(3)(A).

The Department of Health and Human Services did not revise the FPL guidelines for 2010, so there are no changes to the MMMNA and ESA standards for 2010.

Policy:

<table>
<thead>
<tr>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMMNA</td>
<td>$1,821</td>
</tr>
<tr>
<td>ESA</td>
<td>$546</td>
</tr>
</tbody>
</table>

Action Required:

No case alerts will be issued and there will not be a mass change completed by CRIS-E. No manual review of long-term care facility and home & community-based services assistance groups with a community spouse will need to be completed for 2010. The standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

Medicaid Eligibility Policy Letters

<table>
<thead>
<tr>
<th>Location</th>
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</thead>
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<td>MEPL No. 48 (Effective July 1, 2010)</td>
</tr>
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</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 41 (COLA for 2010)

Medicaid Eligibility Procedure Letter No. 41

December 2, 2009

Effective Date: January 1, 2010


To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Consumer Price Index (CPI) Increase

2010 Social Security Cost of Living Adjustment (COLA)

Social Security Income (SSI) Benefit Increase

Railroad Retirement Benefit Increase

RSS COLA Disregard

Medicare Part B Premium Increase

Medicaid Need Standards Increase

Special Income Level (SIL) Increase

Assisted Living Maintenance Needs Allowance (ALMNA) Increase

Special Maintenance Needs Allowance (SMNA) Increase

Spousal Impoverishment Standards Increase

MBIWD Resource Eligibility Limit Increase

Student Child Earned Income Exclusion Increase

Reason for Change: ODJFS is required to make annual adjustments based on the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI, railroad retirement benefits, the RSS disregard, Medicare Part B premium, spousal impoverishment standards, Medicaid need standards, special income level, assisted living maintenance needs allowance, special maintenance needs allowance, MBIWD resource eligibility limit and changes in the student child earned income exclusion.

Prior Policy: The tables in this MEPL include the 2009 standards, benefits, and/or payment amounts along with the amounts for 2010 in bold.

New Policy: The federal government determined there will be no COLA adjustment in 2010. Therefore, there will be no increase in Social Security benefits payable in 2010, nor will there be an increase in SSI payments for 2010. The only change for 2010 is regarding Medicare Part B premiums. If an individual is entitled to benefits under section 202 or 223 of the Social Security Act (as an aged, blind, or disabled individual) for November and December 2009 (which are paid in December 2009 and January 2010, respectively) and the individual's Part B premiums for December 2009 and January 2010 are deducted from the respective month's Social Security benefits, then the individual's premium amount will remain at the 2009 level of $96.40. Individuals who are not entitled to benefits for November and December 2009 as described above, but who become entitled to such benefits after November 2009 will pay the increased Part B premium for 2010.

Social Security and Railroad Retirement Benefits
Social Security benefits and railroad retirement benefits will not increase for 2010.

**SSI Increase**

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$674</td>
<td>$674</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>$1,011</td>
<td>$1,011</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

**RSS Individuals**

Since there is no SSI COLA for 2010, the COLA disregard for the Residential State Supplement (RSS) program will remain the same as for 2009. The following chart provides the SSI COLA and the total amounts to be disregarded to date when determining financial eligibility and cash payments for RSS individuals.

<table>
<thead>
<tr>
<th>DISREGARD OF SSI COLA INCREASE</th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum single individual SSI benefit</td>
<td>2009</td>
<td>2010</td>
<td>2009</td>
</tr>
<tr>
<td></td>
<td>$674</td>
<td>$674</td>
<td>$37</td>
</tr>
<tr>
<td>Maximum couple SSI benefit</td>
<td>2009</td>
<td>2010</td>
<td>2009</td>
</tr>
<tr>
<td></td>
<td>$1,011</td>
<td>$1,011</td>
<td>$56</td>
</tr>
</tbody>
</table>

**Medicare Premium**

<table>
<thead>
<tr>
<th>MEDICAID PART B PREMIUM</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$96.40</td>
<td>$96.40*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$110.50*</td>
</tr>
</tbody>
</table>

* A Medicare beneficiary whose modified adjusted gross income is greater than $85,000 (individual) or $170,000 (filing a joint tax return) is responsible for a larger portion of the cost of Part B coverage. Therefore, in addition to the standard premium (whether that is $96.40 or $110.50 for the individual) such a beneficiary must pay an income-related monthly adjustment amount.

† Note: This increased Medicare premium applies to individuals who become entitled to Social Security Aged, Blind, or Disabled benefits after November 2009 due to late or new enrollment.

**Medicaid Need Standard for Individual/Couple in Own Household**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2009</th>
<th>2010</th>
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<td>$1,011</td>
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**Medicaid Need Standard for Individual/Couple in Household of Another**
### MEDICAID NEED STANDARDS

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
</tr>
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<td>Individual living in household of another</td>
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<td>Couple living in household of another</td>
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<td>$674</td>
</tr>
</tbody>
</table>

### Special Income Level

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$2,022</td>
<td>$2,022</td>
</tr>
</tbody>
</table>

### Assisted Living Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$674</td>
<td>$674</td>
</tr>
</tbody>
</table>

### Special Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1,315</td>
<td>$1,315</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards

<table>
<thead>
<tr>
<th>IMPOVERISHMENT STANDARDS</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
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</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
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<td>$2,739</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2010, when the federal poverty level is updated.

### MBIWD Resource Eligibility Limit

<table>
<thead>
<tr>
<th>MBIWD RESOURCE ELIBILITY LIMIT</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$10,580</td>
<td>$10,580</td>
</tr>
</tbody>
</table>
**Student Child Earned Income Exclusion**

<table>
<thead>
<tr>
<th>Student Exclusion</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (up to)</td>
<td>$1,640</td>
<td>$1,640</td>
</tr>
<tr>
<td>Earned income exclusion (no more than)</td>
<td>$6,600</td>
<td>$6,600</td>
</tr>
</tbody>
</table>

The student child earned income exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

**Long Term Care Facility (LTCF) Individuals**

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5101:1-39-24 and 5101:1-39-24.1.

**Action Required:** Because there is no COLA for 2010, mass change will not be run. No reports, alerts, or notices shall be issued in CRIS-E. However, counties shall use the correct Medicare Part B premium on CRIS-E screen AEFMC when determining eligibility.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 30 (Effective January 1, 2009)</td>
<td>MEPL 41 (Effective January 1, 2010)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**

http://emanuals.odjs.state.oh.us/emanuals

**InnerWeb Calendar:**

http://www.odjs.state.oh.us/lpc/calendar/staff

**Internet Calendar:**

http://www.odjs.state.oh.us/lpc/calendar
MEPL 39 (Medicaid: Standard Utility Allowance Increase)
August 28, 2009

Medicaid Eligibility Procedure Letter No. 39

Effective Date: October 1, 2009
To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid: Standard Utility Allowance Increase

Reason for Change:
Ohio's standard utility allowance in the Food Assistance Program can be used in lieu of an individual's utility expenses when determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the increase in the Food Assistance Program utility standard from $586 to $588, the standard utility allowance for determination of the MMMNA is also being increased.

The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2008) standard as well as the increased amount for 2009 (in bold).

<table>
<thead>
<tr>
<th>Standard Utility Allowance (SUA)</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>$586</td>
<td>$588</td>
<td></td>
</tr>
</tbody>
</table>

Action Required:
For budgets effective on or after October 1, 2009, the standard utility allowance of $588 shall be used when determining the community spouse's monthly income allowance (MIA).

A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2009 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance.

These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All assistance groups affected by the increased utility allowance shall be provided with written notice of proposed action.

Effective October 1, 2009, all new applicants must have eligibility determined using the utility standard of $588.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace/Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 29 (Effective 10/1/2008)</td>
<td>MEPL 39 (Effective 10/1/2009)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar
MEPL 38 (Medicaid: Federal Minimum Wage Increase)  
July 17, 2009

Medicaid Eligibility Procedure Letter No. 38

Effective Date: July 24, 2009


To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Federal Minimum Wage Increase

Reason for change: The Fair Labor Standards Act of 1938, overseen by the U.S. Department of Labor, increases the federal minimum wage to $7.25 per hour, effective July 24, 2009.

Prior Policy: The previous federal minimum wage was $6.55 per hour.

New Policy: The new federal minimum wage is $7.25 per hour, effective July 24, 2009.

<table>
<thead>
<tr>
<th>Federal minimum wage</th>
<th>7/24/2008</th>
<th>7/24/2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$6.55</td>
<td>$7.25</td>
</tr>
</tbody>
</table>

Action Required: No desk review is required by county workers. Table TWAG is updated to reflect the increased federal minimum wage amount. This new figure should be used for income calculations as described in rules 5101:1-40-20.1 and 5101:1-41-30 of the Administrative Code.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>N/A</td>
<td>MEPL 38 (effective July 24, 2009)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 34 (Increase in the Minimum Monthly Maintenance Needs Allowance [MMMNA] and Excess Shelter Allowance [ESA] Standards)

May 6, 2009

Medicaid Eligibility Procedure Letter No. 34

Effective Date: July 1, 2009


To: Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason for Change:

Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines per federal requirements established in 42 U.S.C. 1396r-5(d)(3)(A). The Department of Health and Human Services provided the updated FPL guidelines in January 2009, making July 1, 2009, the effective date for the new MMMNA and ESA standards.

New Policy:

The following Medicaid income standards are affected by the increase in the FPL. This table shows the 2009 standard in bold, with the 2008 standards for comparison.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Monthly Maintenance Needs Allowance (MMMNA)</td>
<td>$1,750</td>
<td>$1,821</td>
</tr>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$ 513</td>
<td>$ 546</td>
</tr>
</tbody>
</table>

Action Required:

No case alerts will be issued and there will not be a mass change completed by CRIS-E. Therefore, a manual review of all long-term care facility and home and community-based services assistance groups with a community spouse will need to be completed. A CRIS-E view flash bulletin (CLVB) has been issued with the information contained in this MEPL. The new standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

Medicaid Eligibility Policy Letters

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 28</td>
<td>MEPL No. 34</td>
</tr>
<tr>
<td></td>
<td>(Effective July 1, 2008)</td>
<td>(Effective July 1, 2009)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 33 (Medicaid: 2009 Federal Poverty Level Income Guidelines Medicaid Buy-In for Workers with Disabilities [MBIWD])

February 19, 2009

Medicaid Eligibility Procedure Letter No. 33

Effective Date: January 1, 2009

OAC Rule: 5101:1-41-30

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: 2009 Federal Poverty Level Income Guidelines Medicaid Buy-In for Workers with Disabilities (MBIWD)

Reason for Change: In January 2009, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guideline for the MBIWD program has changed effective January 1, 2009.

Actions Required: Beginning January 1, 2009, the CDJFS must determine initial and ongoing eligibility for the MBIWD individual using the 250% FPL income guideline. The increased amount for 2009 is in bold print (below):

<table>
<thead>
<tr>
<th>Individual Income Guideline 250%</th>
<th>$2,257</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,167 (2008)</td>
</tr>
</tbody>
</table>

For any cases identified as denied or terminated since January 1, 2009 using the previous year's FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in table TMEP.

For individuals who are already approved for MBIWD, the CDJFS is required to rerun the budgets, which includes redetermining the premium. When the CDJFS has determined the updated premium is lower, the CDJFS must reduce the individual's premium obligation. However, the CDJFS shall not increase the premium of any MBIWD individual until the annual redetermination.

<table>
<thead>
<tr>
<th>2009 Monthly FPL Income Guidelines for Premium Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

A mass change will not be run for MBIWD individuals. However, instructions on how to generate the necessary reports using the Business Information Channel will be available as a desk aid in the MEM titled, "MBIWD FPL BIC Report Instructions". The data needed to generate this report should be available in BIC beginning on February 9, 2009.
For any cases identified as denied or terminated using the previous year's FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in table TMEP. To determine whether eligibility needs to be determined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go to step 2.

2. Review IQCT - If AEORE or AEABC was last run on or before January 31, 2009, re-run the case to redetermine eligibility.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standard can be found in CRIS-E reference table TMEP.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>N/A</td>
<td>MEPL 33</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective January 1, 2009)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals:**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 32 (Medicaid: 2009 Federal Poverty Level Income Guidelines for Low Income Medicare Premium Assistance Program)

February 11, 2009

Medicaid Eligibility Procedure Letter No. 32

Effective Date: March 1, 2009


To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: 2009 Federal Poverty Level Income Guidelines for Low Income Medicare Premium Assistance Programs

Reason for Change: In January, 2009, the United States Department of Health and Human Services updated federal poverty level (FPL) income guidelines.

New Policy: Federal poverty level income guidelines for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective March 1, 2009.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRIS in table TMEP. The increased amounts for 2009 are in bold print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% FPL</td>
<td>$903</td>
<td>$1,215</td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary (SLMB) 120% FPL</td>
<td>$1,083</td>
<td>$1,457</td>
</tr>
<tr>
<td></td>
<td>$1,040 (2008)</td>
<td>$1,400 (2008)</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% FPL</td>
<td>$1,219</td>
<td>$1,640</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI) 200% FPL</td>
<td>$1,805</td>
<td>$2,429</td>
</tr>
</tbody>
</table>

Action Required: Table TMEP will be updated before CRIS’s adverse action cut off for March budgets. The change will automatically recalculate budgets on authorized cases. For cases where the mass change was not completed, the system generates an alert #372 instructing the case worker to rerun the budgets. Counties must rerun these cases to update the cost-of-living adjustment (COLA) increases.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 24 (Effective March 1, 2008)</td>
<td>MEPL 32 (Effective March 1, 2009)</td>
</tr>
</tbody>
</table>
MEPL 24 is obsolete upon the effective date of this MEPL.

This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals:**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEDICAL ELIGIBILITY PROCEDURE LETTER NO. 31

February 11, 2009

Effective Date: January 1, 2009

OAC Rule: 5101:1-40-26

To: All Medicaid Eligibility Manual Holders

From: Douglas E. Lumpkin, Director

Subject: Medicaid: 2009 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and Transitional Medical Assistance

Reason for Change: In January, 2009, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guidelines for Healthy Start, Healthy Families, and Transitional Medical Assistance programs have changed effective January 1, 2009.

Action Required: Beginning January 1, 2009, the CDJFS must determine initial and ongoing eligibility for Healthy Start, Healthy Families, and Transitional Medicaid using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Families 90%</th>
<th>Healthy Start 150%</th>
<th>Transitional 185%</th>
<th>Pregnant Women &amp; Healthy Start 200%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$813</td>
<td>$1,354</td>
<td>$1,670</td>
<td>$1,805</td>
</tr>
<tr>
<td>2</td>
<td>$1,093</td>
<td>$1,822</td>
<td>$2,247</td>
<td>$2,429</td>
</tr>
<tr>
<td>3</td>
<td>$1,374</td>
<td>$2,289</td>
<td>$2,823</td>
<td>$3,052</td>
</tr>
<tr>
<td>4</td>
<td>$1,654</td>
<td>$2,757</td>
<td>$3,400</td>
<td>$3,675</td>
</tr>
<tr>
<td>5</td>
<td>$1,935</td>
<td>$3,224</td>
<td>$3,976</td>
<td>$4,299</td>
</tr>
<tr>
<td>6</td>
<td>$2,215</td>
<td>$3,692</td>
<td>$4,553</td>
<td>$4,922</td>
</tr>
</tbody>
</table>

*This standard is used for children when no creditable insurance exists.

A mass change will not be run for these individuals. However, a desk aid called "CFC FPL BIC Report Instructions" is available in the Medicaid Eligibility Manual (MEM) describing how to generate the Healthy Families/ Healthy Start/Transitional Medical Assistance Closure Report using the Business Information Channel. The data needed to generate this report should be available in BIC beginning on February 9, 2009.

For any cases identified as denied or terminated using the previous year’s FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in table THST. To determine whether eligibility needs to be determined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go on to step 2.

2. Review IQCT - If AEORE or AEABC was last run on or before January 31, 2009, re-run the case to redetermine eligibility.
A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table THST.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 23 (Effective January 1, 2008)</td>
<td>MEPL 31 (Effective January 1, 2009)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 23 is obsolete upon the effective date of this MEPL. This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals:**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
Medicaid Eligibility Procedure Letter No. 30

Effective Date: January 1, 2009


To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Consumer Price Index (CPI) Increase

2008 Social Security Cost of Living Adjustment (COLA)
Social Security Income (SSI) Benefit Increase
Railroad Retirement Benefit Increase
Medicare Part B Premium Increase
Spousal Impoverishment Standards Increase
Medicaid Need Standards
MBIWD Resource Eligibility Increase
Student Child Earned Income Exclusion

Reason for Change: ODJFS is required to make annual adjustments based on the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI, railroad retirement benefits, Medicare Part B premium, spousal impoverishment standards, and Medicaid need standards, special income level, special maintenance needs allowance, MBIWD resource eligibility limit and changes in the student child earned income exclusion for 2009.

Prior Policy: The tables in this MEPL show the 2008 standards, benefits, and/or payment amounts with the increased amounts for 2009 in bold.

New Policy: Effective January 1, 2009, a 5.8% increase in the CPI and COLA resulted in the adjustment of standards contained below:

Social Security and Railroad Retirement Benefits
Social Security benefits and railroad retirement benefits will increase by 5.8% January 1, 2009. The 2009 COLA increase for Social Security and railroad retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals until February 28, 2009. For QMB or SLMB individuals, the COLA is only disregarded for the QMB or SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individual's Social Security benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 5.8% COLA.

Note: In 2009, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards. Information regarding the necessary CDJFS activity for these changes will be provided in another MEPL.

SSJ Increase

SSI PAYMENT AMOUNTS
<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$637</td>
<td>$674</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>$956</td>
<td>$1,011</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

**RSS Individuals**

The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

**DISREGARD OF SSI COLA INCREASE**

<table>
<thead>
<tr>
<th></th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008</td>
<td>2009</td>
<td>2008</td>
</tr>
<tr>
<td>Maximum single individual SSI benefit</td>
<td>$637</td>
<td>$674</td>
<td>$15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2008</td>
<td>2009</td>
</tr>
<tr>
<td>Maximum couple SSI benefit</td>
<td>$956</td>
<td>$1,011</td>
<td>$22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2008</td>
<td>2009</td>
</tr>
</tbody>
</table>

**Medicare Premium**

**MEDICAID PART B PREMIUM**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$96.40*</td>
<td>$96.40*</td>
</tr>
</tbody>
</table>

*Note: This Medicare premium remains the same as 2008 and applies to an individual who earns $85,000 or less or a couple who earns $170,000 or less.

**Medicaid Need Standard for Individual/Couple in Own Household**

**MEDICAID NEED STANDARDS**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$556</td>
<td>$589</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$956</td>
<td>$1,011</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Household of Another**

**MEDICAID NEED STANDARDS**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$371</td>
<td>$393</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$637</td>
<td>$674</td>
</tr>
</tbody>
</table>

**Special Income Level**
### SPECIAL INCOME LEVEL

<table>
<thead>
<tr>
<th>Institutionized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,911</td>
<td>$2,022</td>
<td></td>
</tr>
</tbody>
</table>

### Assisted Living Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$637</td>
<td>$674</td>
</tr>
</tbody>
</table>

### Special Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1,243</td>
<td>$1,315</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards

<table>
<thead>
<tr>
<th>IMPOVERISHMENT STANDARDS</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$20,880</td>
<td>$21,912</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$104,400</td>
<td>$109,560</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,610</td>
<td>$2,739</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2009, when the federal poverty level is updated.

### MBIWD Resource Eligibility Limit

<table>
<thead>
<tr>
<th>MBIWD RESOURCE ELIBILITY LIMIT</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$10,000</td>
<td>$10,580</td>
</tr>
</tbody>
</table>

### Student Child Earned Income Exclusion

<table>
<thead>
<tr>
<th>STUDENT EXCLUSION</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (up to)</td>
<td>$1,550</td>
<td>$1,640</td>
</tr>
<tr>
<td>Earned income exclusion (no more than)</td>
<td>$6,240</td>
<td>$6,600</td>
</tr>
</tbody>
</table>

This exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child’s own income and
applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

Long Term Care Facility (LTCF) Individuals

**Instructions for determining any change in the patient liability for individuals in institutions, individuals** receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5101:1-39-24 and 5101:1-39-24.1.

After the mass change is run, ODJFS will issue report BON003-R002, which is a summary of all individuals by LTCF.

Because of the increase in patient liability, case workers must issue prior notice for adverse action before December 15, 2008. If the adverse action notice is issued after December 15, then the increase cannot be effective until February 1, 2009, as it would be an error.

**CRIS-E**

CRIS-E performs a mass change beginning November 27, 2008 to update items listed in this MEPL effective January 1, 2009.

- CRIS-E will generate alerts to case workers regarding cases updated by the mass change.
- To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.
- The CDJFS must provide notice to individuals bypassed during mass change, in accordance with OAC 5101:6-2-04.
- CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the last day of the month following the month that the publication of the revised annual federal poverty level is issued.

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

**MEM Instructions:**

Medicaid Eligibility Procedure Letter:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 22 (Effective January 1, 2008)</td>
<td>MEPL 30 (Effective January 1, 2009)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM):**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
Medicaid Eligibility Procedure Letter No. 29

Effective Date: October 1, 2008


To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: Standard Utility Allowance Increase

Reason for change:
Ohio’s standard utility allowance in the Food Stamp program can be used in lieu of an individual’s utility expenses when determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the increase in the Food Stamp utility standard from $450 to $586, the standard utility allowance for determination of the MMMNA is also being increased.

The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.

For reference purposes, this table shows the previous (2007) standard as well as the increased amount for 2008 (in bold).

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Utility Allowance (SUA)</td>
<td>$450</td>
<td>$586</td>
</tr>
</tbody>
</table>

Action Required:
For budgets effective on or after October 1, 2008, the standard utility allowance of $586 shall be used when determining the community spouse's monthly income allowance (MIA). A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2008 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All assistance groups affected by the increased utility allowance shall be provided with written notice of proposed action.

Effective October 1, 2008, all new applicants must have eligibility determined using the utility standard of $586.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found in CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 19 (Effective October 1, 2007)</td>
<td>MEPL 29 (Effective October 1, 2008)</td>
</tr>
</tbody>
</table>

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 28 (Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards)

May 19, 2008

Medicaid Eligibility Procedure Letter No. 28

Effective Date: July 1, 2008


To: Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason for Change:

Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines per federal requirements established in 42 USC 1396r-5 (d)(3)(A). The Department of Health and Human Services provided the updated FPL guidelines in January, 2008, making July 1, 2008, the effective date for the new MMMNA and ESA standards.

New Policy:

In accordance with the above reason for change, the following Medicaid income standards are affected by the increase in the FPL. This table shows the 2007 standard and the 2008 standard in bold.

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Monthly Maintenance Needs Allowance (MMMNA)</td>
<td>$1,711</td>
<td>$1,750</td>
</tr>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$513</td>
<td>$525</td>
</tr>
</tbody>
</table>

Action Required:

No case alerts will be issued and there will not be a mass change completed by CRIS-E. Therefore, a manual review of all long term care facility and home & community based services assistance groups with a community spouse will need to be completed. A CRIS-E view flash bulletin (CLVB) has been issued with the information contained in this MEPL. The new standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

Medicaid Eligibility Policy Letters

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 18 (Effective July 1, 2007)</td>
<td>MEPL No. 28 (Effective July 1, 2008)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.oddfs.state.oh.us/lpc/calendar/
Medicaid Eligibility Procedure Letter No. 26

Effective Date: February 13, 2008


To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: Tax Refunds under the Economic Stimulus Act of 2008

Reason for Change: Public Law No. 110-185 (the "Economic Stimulus Act of 2008") calls for tax credits or refunds ranging between $300 and $600 per eligible individual, with an additional $300 per qualifying child. These credits or refunds will be made beginning in May, 2008.

Section 101(d) of Public Law No. 110-185 specifies that tax credits or refunds advanced under the Economic Stimulus Act of 2008 are not considered income to the recipient; these tax credits or refunds are also not considered a resource in the month of receipt or the following two months.


These tax credits or refunds should not be used to determine the amount of an individual's spenddown under rule 5101:1-39-10, "Medicaid: Eligibility Through the Spenddown Process" or to determine a premium under 5101:1-41-30 "Medicaid: medicaid buy-in for workers with disabilities (MBIWD)". They should also not be used to determine the amount of patient liability under rule 5101:1-39-24 "Medicaid: Determining Patient Liability" or 5101:1-39-24.1 "Medicaid: Income and Patient Liability Determinations for Individuals Under the Assisted Living Home and Community Based Waiver".

Additionally, in the month of receipt and for two months following the month of receipt, these tax credits or refunds should not be considered an available or countable resource under rule 5101:1-39-05 "Medicaid: Resource Requirement", 5101:1-40-14 "Covered Families and Children (CFC) Medicaid: Resources: Application, Definitions, Availability, and Limitations", or 5101:1-41-30 "Medicaid: Medicaid Buy-In for Workers with Disabilities (MBIWD)".

Action Required: The CDJFS must not treat tax credits or refunds paid under the Economic Stimulus Act of 2008 as income in eligibility determinations or budgeting for any Medicaid program.

In the month of receipt, and for the following two months, the CDJFS must not treat these tax credits or refunds as available or countable resources for any Medicaid program. In the third month after the month of receipt, the CDJFS must determine resource eligibility for any Medicaid program without consideration of whether the resource is or was a tax credit or refund.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>N/A</td>
<td>MEPL 26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Effective February 13, 2008)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 25 (Medicaid: State Mileage Rate Increase)

March 28, 2008

Medicaid Eligibility Procedure Letter No. 25

Effective Date: May 1, 2008


To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: State Mileage Rate Increase

Reason for Change: Individuals may use the state mileage rate to reduce countable income in qualifying for Medicaid. The State of Ohio Department of Administrative Services increased the state mileage rate from $.30 to $.50.5 per mile. Ohio Health Plans will be using $.51 per mile due to limitations within the eligibility system.

Prior Policy: The state mileage rate was $.30 prior to 7/1/06.

New Policy: Effective 5/1/08 the state mileage rate increased to $.51 per mile.

Action Required: Individuals with self-employment deductions from mileage and consumers who utilize mileage expenses in their spenddown calculations are affected by this change. However, there is no desk review required.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
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</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>N/A</td>
<td>MEPL No. 25 (effective 5/1/08)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
**MEPL 24(Medicaid: 2008 Federal Poverty Level Income Guidelines for Low Income Medicare Premium Assistance Programs)**

February 7, 2008

**Medicaid Eligibility Procedure Letter No. 24**

**Effective Date:** March 1, 2008


To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: 2008 Federal Poverty Level Income Guidelines for Low Income Medicare Premium Assistance Programs

**Reason for Change:** In January, 2008, the United States Department of Health and Human Services updated federal poverty level (FPL) income guidelines.

**New Policy:** Federal poverty level income guidelines for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective March 1, 2008.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRISE in table TMEP. The increased amounts for 2008 are in **bold** print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% FPL</td>
<td>$867</td>
<td>$1,167</td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary (SLMB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>120% FPL</td>
<td>$1,040</td>
<td>$1,400</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>135% FPL</td>
<td>$1,170</td>
<td>$1,575</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200% FPL</td>
<td>$1,734</td>
<td>$2,334</td>
</tr>
</tbody>
</table>

**Action Required:** Table TMEP will be updated before CRISE’s adverse action cut off for March budgets. The change will automatically recalculate budgets on authorized cases. For cases where the mass change was not completed, the system generates an alert instructing the case worker to rerun the budgets. Counties must rerun these cases to update the cost-of-living adjustment (COLA) increases.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 16</td>
<td>MEPL 24</td>
</tr>
<tr>
<td></td>
<td>(Effective April 1, 2007)</td>
<td>(Effective March 1, 2008)</td>
</tr>
</tbody>
</table>

MEPL 16 is obsolete upon the effective date of this MEPL.
This MEPL is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM):**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 23(Medicaid: 2008 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and Transitional Medical Assistance)

February 7, 2008

Medicaid Eligibility Procedure Letter No. 23

Effective Date: January 1, 2008

OAC Rule: 5101:1-40-26

To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: 2008 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and Transitional Medical Assistance

Reason for Change: In January, 2008, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.

New Policy: The FPL income guidelines for Healthy Start, Healthy Families, and Transitional Medical Assistance programs have changed effective January 1, 2008.

Action Required: Beginning January 1, 2008, the CDJFS must determine initial and ongoing eligibility for Healthy Start, Healthy Families, and Transitional Medicaid using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Families 90%</th>
<th>Healthy Start 150%</th>
<th>Transitional 185%</th>
<th>Healthy Start 200%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$780</td>
<td>$1,300</td>
<td>$1,604</td>
<td>$1,734</td>
</tr>
<tr>
<td>2</td>
<td>$1,050</td>
<td>$1,750</td>
<td>$2,159</td>
<td>$2,334</td>
</tr>
<tr>
<td>3</td>
<td>$1,320</td>
<td>$2,200</td>
<td>$2,714</td>
<td>$2,934</td>
</tr>
<tr>
<td>4</td>
<td>$1,590</td>
<td>$2,650</td>
<td>$3,269</td>
<td>$3,534</td>
</tr>
<tr>
<td>5</td>
<td>$1,860</td>
<td>$3,100</td>
<td>$3,824</td>
<td>$4,134</td>
</tr>
<tr>
<td>6</td>
<td>$2,130</td>
<td>$3,550</td>
<td>$4,379</td>
<td>$4,734</td>
</tr>
</tbody>
</table>

*This standard is used when no creditable insurance exists.

A mass change will not be run for these individuals. However, each county director will be sent instructions on how to generate the Healthy Families/Healthy Start/Transitional Medical Assistance Closure Report using the Business Information Channel. The data needed to generate this report should be available in BIC beginning on February 11, 2008.

For any cases identified as denied or terminated using the previous year's FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in table THST. To determine whether eligibility needs to be determined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go on to step 2.

2. Review IQCT - If AEORE or AEABC was last run on or before January 31, 2008, re-run the case to redetermine eligibility.
A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table THST.

**MEM Instructions:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 15</td>
<td>MEPL 23</td>
</tr>
<tr>
<td></td>
<td>(Effective January 1, 2007)</td>
<td>(Effective January 1, 2008)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 15 is obsolete upon the effective date of this MEPL. This MEPL is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM):**
http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 22 (2008 Social Security Cost of Living Adjustment {COLA})

Medicaid Eligibility Procedure Letter No. 22

November 19, 2007

Effective Date: January 1, 2008


To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Consumer Price Index (CPI) Increase

2008 Social Security Cost of Living Adjustment (COLA)

Social Security Income (SSI) Benefit Increase

Railroad Retirement Benefit Increase

Medicare Part B Premium Increase

Spousal Impoverishment Standards Increase

Medicaid Need Standards

Student Child Earned Income Exclusion

Reason for Change: ODJFS is required to make annual adjustments based on the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI, railroad retirement benefits, Medicare Part B premium, spousal impoverishment standards, and Medicaid need standards, special income level, special maintenance needs allowance and changes in the student child earned income exclusion for 2008.

Prior Policy: The tables in this MEPL show the 2007 standards, benefits, and/or payment amounts with the increased amounts for 2008 in bold.

New Policy: Effective January 1, 2008, a 2.3% increase in the CPI and COLA resulted in the adjustment of standards contained below:

Social Security and Railroad Retirement Benefits

Social Security benefits and railroad retirement benefits will increase by 2.3% January 1, 2008. The 2008 COLA increase for Social Security and railroad retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals until February 29, 2008. For QMB or SLMB individuals, the COLA is only disregarded for the QMB or SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individual's Social Security benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 2.3% COLA.

Note: In 2008, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards. Information regarding the necessary CDJFS activity for these changes will be provided in another MEPL.

SSI Increase

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>2007</td>
</tr>
<tr>
<td>Single individual living independently</td>
</tr>
</tbody>
</table>
Couple living independently | $934 | $956

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

**RSS Individuals**

The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

<table>
<thead>
<tr>
<th></th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>

**Medicare Premium**

<table>
<thead>
<tr>
<th>MEDICAID PART B PREMIUM</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$93.50*</td>
<td>$96.40*</td>
</tr>
</tbody>
</table>

*Note: This Medicare premium applies to an individual who earns $82,000 or less or a couple who earns $164,000 or less.

**Medicaid Need Standard for Individual/Couple in Own Household**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$543</td>
<td>$556</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$934</td>
<td>$956</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Household of Another**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$362</td>
<td>$371</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$623</td>
<td>$637</td>
</tr>
</tbody>
</table>

**Special Income Level**

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Institution/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,869</td>
<td>$1,911</td>
<td></td>
</tr>
</tbody>
</table>

### Assisted Living Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$623</td>
<td>$637</td>
</tr>
</tbody>
</table>

### Special Maintenance Needs Allowance

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1,215</td>
<td>$1,243</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards

<table>
<thead>
<tr>
<th>IMPOVERISHMENT STANDARDS</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$20,328</td>
<td>$20,880</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$101,640</td>
<td>$104,400</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,541</td>
<td>$2,610</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2008, when the federal poverty level is updated.

### Student Child Earned Income Exclusion

<table>
<thead>
<tr>
<th>STUDENT EXCLUSION</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (up to)</td>
<td>$1,510</td>
<td>$1,550</td>
</tr>
<tr>
<td>Earned income exclusion (no more than)</td>
<td>$6,100</td>
<td>$6,240</td>
</tr>
</tbody>
</table>

This exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child’s own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

### Long Term Care Facility (LTCF) Individuals

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, individuals receiving services under the program of all inclusive care for the elderly (PACE), or individuals receiving assisted living waiver services are found in rules 5101:1-39-24 and 5101:1-39-24.1.
After the mass change is run, ODJFS will issue report BON003-R002, which is a summary of all individuals by LTCF.

Because of the increase in patient liability, case workers must issue prior notice for adverse action before December 13, 2007. If the adverse action notice is issued after December 13, then the increase cannot be effective until February 1, 2008, as it would be an error.

**CRIS-E**

CRIS-E performs a mass change beginning November 24, 2007 to update items listed in this MEPL effective January 1, 2008.

- CRIS-E will generate alerts to case workers regarding cases updated by the mass change.
- To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.
- The CDJFS must provide notice to individuals bypassed during mass change, in accordance with OAC 5101:6-2-04.
- CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the last day of the month following the month that the publication of the revised annual federal poverty level is issued.

A CRIS-E view flash bulletin (CLVB) will be issued with the information contained in this MEPL.

**MEM Instructions:**

Medicaid Eligibility Procedure Letter:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 13 (Effective January 1, 2007)</td>
<td>MEPL 22 (Effective January 1, 2008)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM):**

http://emanuals.odjfs.state.oh.us/emanuals/

**InnerWeb Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 20 (Medicaid: Verification and Reporting Requirements for U.S. Citizenship)

Medicaid Eligibility Procedure Letter No. 20

September 6, 2007

Effective Date: July 13, 2007

OAC Rules: 5101:1-38-02 Medicaid: Verification and Reporting Requirements

To: All Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: Verification and Reporting Requirements for U.S. Citizenship


Prior Policy: Medicaid Eligibility Manual Transmittal Letter No. 37 addressed amended federal legislation excluding additional groups from the citizenship verification requirement, including individuals receiving foster care or adoption assistance under Title IV-E, those in foster care receiving child welfare services under Title IV-B, and those receiving Social Security Disability Insurance (SSDI). Clarification of the citizenship verification and reporting requirement as it pertains to newborns was added to the rule.

New Policy: The federal government issued final rules for verification of U.S. citizenship to qualify for Medicaid. As a result, numerous acceptable supplemental documents have been added to the list, and include the following:

For verification of birth or nationality, acceptable documents/verification now include the use of Systematic Alien Verification for Entitlements (SAVE), Child Citizenship Act of 2000 documents, religious records, early school records, affidavits for naturalized citizens, and Roll of Alaska Natives documents.

For verification of identity, acceptable documents/verification now include the use of school records for children under age 16 and "three corroborating documents" that together reasonably corroborate the identity of an individual if not used also for birth or nationality verification. Additionally, identity affidavits are acceptable for the following individuals: Disabled individuals in residential care facilities made by the administrator or director of the facility; and, children between the ages of 16 and 18, if no school ID card with photograph or no driver’s license is available.

There is no federal or state requirement that affidavits be notarized, regardless of whether it is used for birth and nationality or identity purposes.

Action Required: The new federal legislation retroactively applies to all applicants for or recipients of Medicaid programs beginning July 13, 2007. Any individuals who were denied with CRIS-E reason codes 852 or 853 due to citizenship verification must be reviewed for eligibility. This information may be accessed by using the BIC application timeliness data cube.

CRIS-E reference table TMCV was updated to include several new document types for birthplace/nationality verification as well as new types of identity verification.

Rule 5101:1-38-02, "Medicaid: verification and reporting requirements," will be amended to include this information. A desk aid, containing more specific information, is provided to county departments of job and family services along with this MEPL.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Insert</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td></td>
<td>MEPL No. 20</td>
</tr>
</tbody>
</table>
This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**  
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**  
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**  
http://www.odjfs.state.oh.us/lpc/calendar/

**MEPL 20 Attachment: Citizenship Desk Aid**  
Click here to view the MEPL 20 Attachment, Citizenship Desk Aid:
MEPL 19 (Medicaid: Standard Utility Allowance Increase)

Medicaid Eligibility Procedure Letter No. 19

August 15, 2007

Effective Date: October 1, 2007
To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Standard Utility Allowance Increase

Reason for Change:
Ohio’s standard utility allowance in the Food Stamp program can be used in lieu of using individual utility expenses and determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the increase in the Food Stamp utility standard, the standard utility allowance for determination of the MMMNA is also being increased. The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse’s monthly income.

Prior Policy: The standard utility allowance was $429.

New Policy: Effective October 1, 2007, the standard utility allowance of $429 is increased to $450.

Action Required:
With budgets that are effective October 1, 2007, the standard utility allowance of $450 shall be used when determining the community spouse’s monthly income allowance (MIA). A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2007 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance. These cases (MAM) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All assistance groups affected by the increased utility allowance shall be provided with written notice of proposed action.

For reference purposes, the table shows the previous (2006) standard in parenthesis. The increase amount for 2007 is printed in bold.

<table>
<thead>
<tr>
<th>Effective October 1, 2007, all new applicants must be determined using the standard of $450.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Utility Allowance (SUA)</td>
</tr>
<tr>
<td>(2006)</td>
</tr>
</tbody>
</table>

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found in CRIS-E reference table TEMP.

MEM Instructions:

Medicaid Eligibility Procedure Letters

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 12 (Effective October 1, 2006)</td>
<td>MEPL No. 19 (Effective October 1, 2007)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 18 Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Medicaid Eligibility Procedure Letter No. 18

May 1, 2007

Effective Date: July 1, 2007


To: Medicaid Eligibility Manual Holders

From: Helen E. Jones-Kelley, Director

Subject: Medicaid: Increase in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Standards

Reason for Change:

Annual changes to the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Excess Shelter Allowance (ESA) standards are effective with the second quarter following publication of the Federal Poverty Level (FPL) guidelines per federal requirements established in 42 USC 1396r-5 (d)(3)(A). The Department of Health and Human Services provided the updated FPL guidelines in January, 2007, making July 1, 2007, the effective date for the new MMMNA and ESA standards.

New Policy:

In accordance with the above reason for change, the following Medicaid income standards are affected by the increase in the FPL. This table shows the 2006 standard and the 2007 standard in bold.

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Monthly Maintenance Needs</td>
<td>$1,650</td>
<td>$1,711</td>
</tr>
<tr>
<td>Allowance (MMMNA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$495</td>
<td>$513</td>
</tr>
</tbody>
</table>

Action Required:

No case alerts will be issued and there will not be a mass change completed by CRIS-E. Therefore, a review of all Long Term Care Facility and Home & Community Based Services assistance groups with a community spouse will need to be completed. A CRIS-E view flash bulletin (CLVB) has been issued with the information contained in this MEPL. The new standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

Medicaid Eligibility Policy Letters

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 11, 11A</td>
<td>MEPL No. 18</td>
</tr>
<tr>
<td></td>
<td>(Effective July 1, 2006)</td>
<td>(Effective July 1, 2007)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 17 Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities

Medicaid Eligibility Procedure Letter No. 17

May 1, 2007

Effective Date: June 1, 2007
OAC Rules: 5101:1-39-07 Medicaid: transfer of resources

5101:1-39-10 Medicaid: eligibility through the spenddown process

To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: Increase in the Average Private Pay Rate for Nursing Facilities

Reason for Change: The Ohio Department of Aging has provided an updated average private pay rate for nursing facilities. Effective June 1, 2007, the average monthly private pay rate is $5247.

Prior Policy: The previous average private pay rate, last updated in 2005, was $4806.

New Policy: The updated private pay rate for nursing facilities is $5247.

Action Required: A new period of restricted coverage is not computed for individuals currently in a penalty period. The CDJFS is not required to re-compute an improper transfer penalty period unless there is new information regarding the improper transfer (e.g. the resource was returned to the individual). The original notice that was issued to the applicant/recipient is still valid.

CRIS-E reference table TMEP has been updated to reflect this increase for recurring budgets effective June 1, 2007.

A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 3 (Effective June 1, 2007)</td>
<td>MEPL No. 17 (Effective June 1, 2007)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 3 is obsolete upon the effective date of this MEPL.

This MEPL is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 16 Medicaid: 2007 Federal Poverty Level Income Guidelines for Low Income Medicare Assistance Programs

Medicaid Eligibility Procedure Letter No. 16

February 8, 2007

Effective Date: April 1, 2007
To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: 2007 Federal Poverty Level Income Guidelines for Low Income Medicare Assistance Programs


New Policy: Federal poverty level income guidelines for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective April 1, 2007.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRISE in table TMEP. The increased amounts for 2007 are in bold print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% FPL</td>
<td>$851</td>
<td>$1,141</td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary (SLMB) 120% FPL</td>
<td>$1,021</td>
<td>$1,369</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% FPL</td>
<td>$1,149</td>
<td>$1,541</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI) 200% FPL</td>
<td>$1,702</td>
<td>$2,282</td>
</tr>
</tbody>
</table>

Action Required: Table TMEP will be updated before CRISE’s adverse action cut off for April budgets. The change will automatically recalculate budgets on authorized cases. For cases where the mass change was not completed, the system generates an alert instructing the case worker to rerun the budgets. Counties must rerun these cases to update the cost-of-living adjustment (COLA) increases.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 10</td>
<td>MEPL 16</td>
</tr>
<tr>
<td></td>
<td>(Effective April 1, 2006)</td>
<td>(Effective April 1, 2007)</td>
</tr>
</tbody>
</table>

MEPL 10 is obsolete upon the effective date of this MEPL.
This MEPL is also available on the Internet and may be accessed at:
ODJFS Electronic Manuals

Medicaid Eligibility Procedure Letter No. 15

February 5, 2007

Effective Date: January 1, 2007
OAC Rule: 5101:1-40-26
To: All Medicaid Eligibility Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: Medicaid: 2007 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and Transitional Medical Assistance

Reason for Change: In January, 2007, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.


Action Required: Beginning January 1, 2007, the CDJFS must determine initial and ongoing eligibility for Healthy Start, Healthy Families, and Transitional Medicaid using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Families 90%</th>
<th>Healthy Start 150%</th>
<th>Transitional 185%</th>
<th>Healthy Start 200%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$766</td>
<td>$1,277</td>
<td>$1,575</td>
<td>$1,702</td>
</tr>
<tr>
<td>2</td>
<td>$1,027</td>
<td>$1,712</td>
<td>$2,111</td>
<td>$2,282</td>
</tr>
<tr>
<td>3</td>
<td>$1,288</td>
<td>$2,147</td>
<td>$2,648</td>
<td>$2,862</td>
</tr>
<tr>
<td>4</td>
<td>$1,549</td>
<td>$2,582</td>
<td>$3,184</td>
<td>$3,442</td>
</tr>
<tr>
<td>5</td>
<td>$1,810</td>
<td>$3,017</td>
<td>$3,721</td>
<td>$4,022</td>
</tr>
<tr>
<td>6</td>
<td>$2,071</td>
<td>$3,452</td>
<td>$4,257</td>
<td>$4,602</td>
</tr>
</tbody>
</table>

*This standard is used when no creditable insurance exists.

A mass change will not be run for these individuals. However, each county director will be sent instructions on how to generate the Healthy Families/Healthy Start/Transitional Medical Assistance Closure Report using the Business Information Channel. The data needed to generate this report should be available in BIC beginning on February 5, 2007.

For any cases identified as denied or terminated using the previous year's FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in table THST. To determine whether eligibility needs to be determined in a case listed on this report:

1. Verify why the case was listed on the report by looking at AEWAA history screens for the authorization date and reason codes. If the case was denied or terminated due to income, go on to step 2.
2. Review IQCT - If AEORE or AEABC was last run on or before January 31, 2007, re-run the case to redetermine eligibility.
A CRIS-E View Flash Bulletin (CLVB) is issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table THST.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL 9 (Effective January 1, 2006)</td>
<td>MEPL 15 (Effective January 1, 2007)</td>
</tr>
</tbody>
</table>

Medicaid Eligibility Policy Letter No. 9 is obsolete upon the effective date of this MEPL.

This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 14 IV-E and SSDI Medicaid Citizenship Verification Requirement

Medicaid Eligibility Procedure Letter No. 14
Family, Children and Adult Services Procedure Letter No. 104

January 26, 2007

Effective Date: September 25, 2006
OAC Rule: 5101:1-38-02
To: Medicaid Eligibility Manual Holders
Family, Children and Adult Services Manual Holders
From: Helen E. Jones-Kelley, Director
Subject: IV-E and SSDI Medicaid Citizenship Verification Requirement

Reason for Change: Amendment to Federal Law

Prior Policy: The Deficit Reduction Act of 2005 required documentation of U.S. citizenship for all applicants and recipients of Medicaid except for those individuals already eligible for Medicare or receiving SSI.

New Policy: New federal legislation signed December 20, 2006, exempts additional groups from the citizenship verification requirement. Individuals receiving foster care or adoption assistance under Title IV-E and those receiving Social Security Disability Insurance (SSDI) will not be required to furnish verification of citizenship in order to be eligible for Medicaid. This exemption is retroactive to the effective date of rule 5101:1-38-02, September 25, 2006.

Action Required: The new federal legislation retroactively applies to IV-E and SSDI individuals beginning September 25, 2006. Therefore, any affected individuals who were terminated or denied with reason codes 852 or 853 due to citizenship verification must be reviewed for eligibility. This information may be accessed by using the BIC Application Timeliness data cube.

CRIS-E table TMCV has been updated to include code "FA" for IV-E foster care and adoption assistance children and "SD" for individuals receiving SSDI. These codes must be used to indicate the individual's IV-E or SSDI status.

Rule 5101:1-38-02, "Medicaid verification and reporting requirements," will be amended to include this information.

Please note this procedure letter relates only to the topic of Medicaid eligibility for children in foster care. It does not relate to other federal requirements that states must have procedures to verify the citizenship of all children in placement. Instructions regarding those procedures will be issued in a separate transmittal.

This procedure letter is also available on the Internet and may be accessed at:

Family, Children and Adult Services Manual (FCASM) and Medicaid Eligibility Manual (MEM):
http://emanuals.ohio.gov/emanuals/

InnerWeb Calendar:
http://www.ohio.gov/lpc/calendar/staff/

Internet Calendar:
http://www.ohio.gov/lpc/calendar/
MEPL 13 Consumer Price Index (CPI) Increase
Medicaid Eligibility Procedure Letter No. 13

November 13, 2006

Effective Date: January 1, 2007

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Consumer Price Index (CPI) Increase

2007 Social Security Cost of Living Adjustment (COLA)

Social Security Income (SSI) Benefit Increase

Railroad Retirement Benefit Increase

Medicare Part B Premium Increase

Spousal Impoverishment Standards Increase

Medicaid Need Standards

Student Child Earned Income Exclusion

Reason for Change: Annual adjustments in the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI, railroad retirement benefits, Medicare Part B premium, spousal impoverishment standards, and Medicaid need standards, special income level, special maintenance needs allowance and changes in the student child earned income exclusion for 2007.

Prior Policy: The tables in this MEPL show the 2006 standards, benefits, and/or payment amounts with the increased amounts for 2007 in bold.

New Policy: Effective January 1, 2007, a 3.3% increase in the CPI and COLA resulted in the adjustment of standards contained below:

Social Security and Railroad Retirement Benefits

Social Security benefits and railroad retirement benefits will increase by 3.3% January 1, 2007. The 2007 COLA increase for Social Security and railroad retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals until the last day of the month following the month the publication of the revised annual federal poverty level is issued. For QMB/SLMB/Medicaid dual eligible individuals, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individual's Title II benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 3.3% COLA.

Note: In 2007, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards. Information regarding the necessary CDJFS activity for these changes will be provided in another MEPL.

SSI Increase

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$603</td>
<td>$623</td>
</tr>
</tbody>
</table>
Couple living independently | $904 | $934

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

**RSS Individuals**

The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

### DISREGARD OF SSI COLA INCREASE

<table>
<thead>
<tr>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum single individual SSI benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum couple SSI benefit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Premium**

**MEDICAID PART B PREMIUM**

<table>
<thead>
<tr>
<th>Medicare Part B Premium</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>$88.50</td>
<td>$93.50*</td>
<td></td>
</tr>
</tbody>
</table>

*Note: The 2007 Medicare Premium is $93.50 for an individual who earns $80,000 or less or a couple who earns $160,000 or less.

**Medicaid Need Standard for Individual/Couple in Own Household**

**MEDICAID NEED STANDARDS**

<table>
<thead>
<tr>
<th>Individual in own household</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>$525</td>
<td>$543</td>
<td></td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$904</td>
<td>$934</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Household of Another**

**MEDICAID NEED STANDARDS**

<table>
<thead>
<tr>
<th>Individual living in household of another</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>$350</td>
<td>$362</td>
<td></td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$603</td>
<td>$623</td>
</tr>
</tbody>
</table>

**Special Income Level**

**SPECIAL INCOME LEVEL**
Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household) | 2006 | 2007 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1809</td>
<td>$1869</td>
<td></td>
</tr>
</tbody>
</table>

**Assisted Living Maintenance Needs Allowance**

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$603</td>
<td>$623</td>
</tr>
</tbody>
</table>

**Special Maintenance Needs Allowance**

<table>
<thead>
<tr>
<th>NEEDS ALLOWANCE</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1178</td>
<td>$1215</td>
</tr>
</tbody>
</table>

**Spousal Impoverishment Standards**

<table>
<thead>
<tr>
<th>IMPOVERISHMENT STANDARDS</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$19,908</td>
<td>$20,328</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$99,540</td>
<td>$101,640</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,489</td>
<td>$2,541</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2007, when the federal poverty level is updated.

**Student Child Earned Income Exclusion**

<table>
<thead>
<tr>
<th>STUDENT EXCLUSION</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned income exclusion (up to)</td>
<td>$1,460</td>
<td>$1,510</td>
</tr>
<tr>
<td>Earned income exclusion (no more than)</td>
<td>$5,910</td>
<td>$6,100</td>
</tr>
</tbody>
</table>

This exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child’s own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

**Long Term Care Facility (LTCF) Individuals**

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, and individuals receiving services under the program of all inclusive care for the elderly (PACE) are found in the Ohio Administrative Code (OAC) 5101:1-39-24 and 5101:1-39-24.1.
After the mass change is run, ODJFS will issue report BON003-R002, which is a summary of all individuals by LTCF.

Because of the increase in patient liability, case workers must issue prior notice for adverse action before December 13, 2006. If the adverse action notice is issued after December 13, then the increase cannot be effective until February 1, 2007, as it would be an error.

CRIS-E

CRIS-E performs a mass change beginning November 23, 2006 to update items listed in this MEPL effective January 1, 2007.

- CRIS-E will generate alerts to case workers regarding cases updated by the mass change.
- To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.
- The CDJFS must provide notice to individuals bypassed during mass change, in accordance with OAC 5101:6-2-04.
- CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the last day of the month following the month that the publication of the revised annual federal poverty level is issued.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

Mem Instructions:

Medicaid Eligibility Procedure Letter:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPLs 7 and 8 (Effective January 1, 2006)</td>
<td>MEPL 13 (Effective January 1, 2007)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM):
http://emanuals.odjfs.state.oh.us/emanuals/

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 12 Medicaid: Standard Utility Allowance Decrease

Medicaid Eligibility Procedure Letter No. 12

September 12, 2006

Effective Date: October 1, 2006


To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Medicaid: Standard Utility Allowance Decrease

Reason for Change:
Ohio’s standard utility allowance in the Food Stamp program can be used in lieu of using individual utility expenses in determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the decrease in the Food Stamp utility standard, the standard utility allowance for determination of the MMMNA is also being decreased. The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse’s monthly income.

Prior Policy: The standard utility allowance was $487

New Policy: Effective October 1, 2006, the standard utility allowance of $487 is decreased to $429.

Action Required:

With budgets that are effective October 1, 2006, the standard utility allowance of $429 shall be used when determining the community spouse’s monthly income allowance (MIA). A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2006 cutoff to ensure the new decreased standard is applied appropriately. The CDJFS must recalculate the MIA using the decreased utility allowance. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E. All assistance groups adversely affected by the decreased utility allowance shall be provided with written notice of the proposed action.

For reference purposes, the table shows the previous (2005) standard in parenthesis. The decreased amount for 2006 is printed in bold.

<table>
<thead>
<tr>
<th>Standard Utility Allowance (SUA)</th>
<th>$429</th>
</tr>
</thead>
<tbody>
<tr>
<td>($487 in 2005)</td>
<td></td>
</tr>
</tbody>
</table>

Effective October, 1, 2006, all new applicants must have eligibility determined using the utility standard of $429.

An Equal Opportunity Employer

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found on CRIS-E reference table TMEP.

MEM Instructions:

Action Change Transmittals

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTs</td>
<td>MEPL No. 4</td>
<td>MEPL No. 12</td>
</tr>
<tr>
<td></td>
<td>(Effective October 1, 2005)</td>
<td>(Effective October 1, 2006)</td>
</tr>
</tbody>
</table>
This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 11A (Medicaid: Income standard changes in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Update)

Medicaid Eligibility Procedure Letter No. 11A

July 6, 2006

Effective Date: July 1, 2006

TO All Medicaid Eligibility Manual Holders
FROM Barbara E. Riley, Director

SUBJECT Medicaid: Income standard changes in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA) Update

Reason for Change:
MEPL No. 11 discussed the income standard changes in the MMMNA and the ESA. MEPL No. 11A addresses the action required to recalculate the community spouse's monthly income allowance (MIA).

New Policy:
The policy related to this procedure letter can be found in MEPL No. 11.

Action Required:
A review of all long term care facility (LTCF) and Home and Community-Based Services (HCBS) assistance groups with a community spouse must be completed.

Prior to the June 21, 2006, CRIS-E cut-off, the CDJFS must recalculate (by running ED/BC) the community spouse's MIA using the allowances in MEPL No. 11. Counties can access the list of affected cases by using the Business Intelligence Channel (BIC) report. The instructions to access the information is as follows:

Access BIC
1. Go to 'Internet Explorer'.
2. Type 'BIC' in address line.
3. From BIC home page, enter your 'User ID' and 'Password'.

Access OHP Data
4. Click on 'OHP - Ohio Health Plans' folder. This brings up the Ohio Health Plans folders to which you have access.
5. Click on 'Ohio Health Plans' folder.

Access Your Report
6. Click on 'OHP Medicaid Eligibility Analysis'. This brings up a report which can be manipulated to create a list of cases affected by the change.

Refine Report to Create Your List
7. Dimensions are listed in the window on the left side of the screen. Each dimension name is next to a 'folder' icon. Click on the 'plus sign' next to the 'Geography' dimension.
8. Click on the 'plus sign' next to the 'All Counties' folder. A list of all counties is displayed.
9. Right click on your county and click 'Filter' from the drop-down box that appears.
10. If you hold your cursor over an icon, the name of the icon is displayed. Click on the 'Swap' icon. This is the fourth icon across the bottom of the report.
11. Click on the 'plus sign' next to the 'Eligibility Month' dimension.
12. Click on the 'plus sign' next to the 'CY 2006' dimension.
13. Click on the 'plus sign' next to the 'CQ 2006 Q2' dimension.
14. Right click on the 'May 2006' icon that appears and click on 'Filter' from the drop-down box that appears.
15. Click on the 'plus sign' next to the 'Marital Status' dimension.
16. Right click on 'Married' and click on 'Filter' from the drop-down box that appears.
17. Click on the 'plus sign' next to the 'Living Arrangement' dimension.
18. Right click on 'Nursing Home (LTCF)' and click on 'Filter' from the drop-down box that appears.
19. Click on the 'Drill Through' icon on the bottom of the screen. This is the third enabled icon from the right of the screen.
20. A new screen appears with three options. Click on 'Eligibility - OHP Medicaid Individuals Demographics DT'.
21. The resulting report provides a list of cases in your county with LTCF residents who are married. These cases need reviewed.

**For Waiver Cases**

22. Repeat the steps above. At Step # 6, click on 'OHP Medicaid Waiver Analysis' instead of 'OHP Medicaid Eligibility Analysis' and continue as instructed. Step # 17 and Step # 18 should be skipped when creating a report of waiver recipients.

No case alerts will be issued and there will not be a mass change completed by CRIS-E. A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL. The new income standards can be found on CRIS-E reference table TMEP.

This MEPL is also available on the Internet and may be accessed at:

**ODJFS Electronic Manuals**

http://emanuals.odjfs.state.oh.us/emanuals

**Medicaid Eligibility Manual (MEM)**

http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 11 Medicaid: Income standard changes in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA)

Medicaid Eligibility Procedure Letter No. 11

May 22, 2006

Effective Date: July 1, 2006
TO: All Medicaid Eligibility Manual Holders
FROM: Barbara E. Riley, Director
SUBJECT: Medicaid: Income standard changes in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA)

Reason for Change:
Per federal requirements, the MMMNA and ESA changes are effective with the second quarter following publication of the Federal Poverty Level (FPL). In January, 2006, the Department of Health and Human Services provided the updated FPL guidelines.

New Policy:
In accordance with the above reason for change, the following Medicaid income standards are affected by the increase in the FPL.

For reference purposes, this MEPL shows the previous (2005) standards in a separate column. The 2006 standards are in bold.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,604</td>
<td>$1,650</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excess Shelter Allowance (ESA)</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$482</td>
<td>$495</td>
</tr>
</tbody>
</table>

Action Required:
A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL. The new income standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

Medicaid Eligibility Policy Letters

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPLs</td>
<td>MEPL No. 2</td>
<td>MEPL No. 11</td>
</tr>
<tr>
<td></td>
<td>(Effective July 1, 2005)</td>
<td>(Effective July 1, 2006)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:
Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/MEM
ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals/
InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
Reason for Change: In January, 2006, the United States Department of Health and Human Services updated federal poverty level (FPL) income guidelines.

New Policy: Federal poverty level income guidelines for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective April 1, 2006.

The FPL increase affects the following Medicaid FPL income guidelines. This information can be found in CRISE in table TMEP. The increased amounts for 2006 are in bold print (below).

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% FPL</td>
<td>$817</td>
<td>$1100</td>
</tr>
<tr>
<td>Specified Low Income Medicare Beneficiary (SLMB) 120% FPL</td>
<td>$980</td>
<td>$1320</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% FPL</td>
<td>$1103</td>
<td>$1485</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI) 200% FPL</td>
<td>$1634</td>
<td>$2200</td>
</tr>
</tbody>
</table>

Action Required: CRIS-E will complete a mass change the night of March 15 for the effective date of April 1, 2006. The mass change will automatically run budgets on authorized cases. For cases where the mass change wasn't completed, the system generates an alert instructing the case worker to rerun the budgets. Counties must rerun these cases to update the cost-of-living adjustment (COLA) increases.

MEM Instructions:
Action Change Transmittal Letter No. 239 is obsolete upon the effective date of this MEPL.
This MEPL is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEDicaid Eligibility Procedure Letter No. 9

February 13, 2006

Effective Date: January 1, 2006

OAC Rules: 5101:1-40-26

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Medicaid: 2006 Federal Poverty Level Income Guidelines for Healthy Families, Healthy Start, and Transitional Medicaid

Reason for Change: In January, 2006, the United States Department of Health and Human Services updated the federal poverty level (FPL) income guidelines.


Action Required: Beginning January 1, 2006, the CDJFS must determine initial and ongoing eligibility for Healthy Start, Healthy Families, and Transitional Medicaid using the following FPL income guidelines:

<table>
<thead>
<tr>
<th>2006 Monthly Federal Poverty Level Income Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

*This standard is used when no creditable insurance exists.

A mass change will not be run for these individuals. However, the Healthy Families/Healthy Start/Transitional Medicaid: Medicaid Closure Report will be generated by ODJFS in an Adobe .pdf format and sent to each county's director via email. For any cases identified as denied or terminated using the previous year's FPL income guidelines, counties must redetermine eligibility using the FPL income guidelines contained in this MEPL.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL. The current income standards can be found in CRIS-E reference table THST.

MEM Instructions:

Action Change Transmittal Letter No. 238 is obsolete upon the effective date of this MEPL.

This MEPL is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM
ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 8
Medicaid Eligibility Procedure Letter No. 8

Effective Date: January 1, 2006
To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Student Child Earned Income Exclusion

Reason for Change: A Consumer Price Index (CPI) increase of 4.1% changed the student child earned income exclusion for 2006.

New Policy: A blind or disabled child, who is a student regularly attending school, college, or university, or a course of vocational or technical training, can have limited earnings that are not counted against his or her Supplemental Security Income (SSI) benefits. Effective January 1, 2006, the student earned income exclusion amounts that are excluded are up to $1,460 per month, but not more than $5,910 in calendar year 2006.

This exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

Action Required: The CDJFS must complete a desk review for all cases from November 26, 2005 to December 31, 2005 and correct all cases in which an individual receives SSI and has an existing student child earned income exclusion.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL. The new Student Child Earned Income Exclusion amounts can be found on CRIS-E reference table TMEP. This MEPL is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpelegibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar
MEPL 7
Medicaid Eligibility Procedure Letter No. 7

November 22, 2005

Effective Date: January 1, 2006

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Consumer Price Index (CPI) Increase

2006 Social Security Cost of Living Adjustment (COLA)
Social Security Income (SSI) Benefit Increase
Railroad Retirement Benefit Increase
Medicare Part B Premium Increase
Spousal Impoverishment Standards Increase
Medicaid Need Standards

Reason for Change: Annual adjustments in the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI, Railroad Retirement benefits, Medicare Part B Premium, Spousal Impoverishment Standards, Medicaid Need Standards, Special Income Level, and Special Maintenance Needs Allowance.

Prior Policy: The tables in this MEPL show the 2005 standards, benefits, and /or payment amounts with the increased amounts for 2006 in bold.

New Policy: Effective January 1, 2006, a 4.1% increase in the CPI and COLA resulted in the adjustment of standards contained below:

Social Security and Railroad Retirement Benefits:

Social Security benefits and Railroad Retirement benefits will increase by 4.1% effective January 1, 2006. The 2006 COLA increase for Social Security and Railroad Retirement benefits will be disregarded for QMB, SLMB, and QI-1 individuals for January, February and March 2006 only. These individuals must have the COLA applied in the financial eligibility determination effective April 1, 2006. For QMB/SLMB/Medicaid dual eligible individuals, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individual's Title II benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 4.1% COLA.

Note: In February, 2006, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards, effective April 1, 2006. Information regarding the necessary CDJFS activity for these changes will be provided in another MEPL.

SSI Increase:

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$579</td>
<td>$603</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>$869</td>
<td>$904</td>
</tr>
</tbody>
</table>
Note: the $30 SSI maximum payment to institutionalized individuals will remain the same.

**RSS Individuals:**
The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS individuals.

<table>
<thead>
<tr>
<th>DISREGARD OF SSI COLA INCREASE</th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>

**Medicare Premium:**

<table>
<thead>
<tr>
<th>MEDICAID PART B PREMIUM</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$78.20</td>
<td>$88.50</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Own Household:**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$504</td>
<td>$525</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$869</td>
<td>$904</td>
</tr>
</tbody>
</table>

**Medicaid Need Standard for Individual/Couple in Household of Another:**

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$336</td>
<td>$350</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$579</td>
<td>$603</td>
</tr>
</tbody>
</table>

**Special Income Level:**

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$1737</td>
<td>$1809</td>
</tr>
</tbody>
</table>

**Special Maintenance Needs Allowance:**
### SPECIAL MAINTENANCE NEEDS ALLOWANCE

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1131</td>
<td>$1178</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards:

#### SPOUSAL IMPOVERISHMENT STANDARDS

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$18,552</td>
<td>$19,908</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$95,100</td>
<td>$99,540</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,319</td>
<td>$2,489</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2006, when the federal poverty level is updated.

### Action Required:

#### Long Term Care Facility (LTCF) Individuals:

Instructions for determining any change in the patient liability for individuals in institutions, individuals receiving HCBS, and individuals receiving services under the program of all inclusive care for the elderly (PACE) are explained in MEMTL 22 dated June 20, 2005.

After the mass change is run, ODJFS will issue a report (BON003-R002) which is a summary of all individuals by LTCF.

The cut-off date for prior notice is December 19, 2005. Any adverse notices regarding an increase in the patient liability after that date are to be effective February 1, 2006. Retrospective adjustments for periods prior to the expiration of the prior notice of an increase in the patient liability, are not correct and should not to be authorized.

#### CRIS-E:

CRIS-E will perform a mass change over the weekend of November 26, 2005 to update the items listed in the Reason for Change section of this MEPL effective January 1, 2006.

CRIS-E will generate appropriate notice to cases updated by the mass change.

To the extent possible, the CDJFS should authorize pending individuals prior to the mass change. Otherwise the mass change action will bypass them.

The CDJFS must provide appropriate notice to individuals bypassed during mass change in accordance with OAC 5101:6-2-04.

CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 individuals until the cut-off for April 2006 benefits.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

This MEPL is also available on the Internet and may be accessed at:

- Medicaid Eligibility Manual (MEM)
  [http://emanuals.odjfs.state.oh.us/emanuals/oheligibility/MEM](http://emanuals.odjfs.state.oh.us/emanuals/oheligibility/MEM)

- ODJFS Electronic Manuals
  [http://emanuals.odjfs.state.oh.us/emanuals](http://emanuals.odjfs.state.oh.us/emanuals)
InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 5 (Consumer notices)

Medicaid Eligibility Procedure Letter No. 5

November 4, 2005

Effective Date: October 13, 2005 through January 1, 2006

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Consumer notices: Medicare Part D prescription drug coverage

Medicaid and DMA co-payments

New limits on covered dental services

Reason for Change: Beginning the week of October 17, 2005, notices were mailed to Medicaid and Disability Medical Assistance (DMA) consumers advising them of the changes to their covered dental services, new co-payment requirements for services rendered, and prescription drug coverage for individuals with both Medicare and Medicaid. These changes occurred because of new state or federal law. Notices were sent to over 1.2 million consumers and authorized representatives.

Action Required: To ensure all new Medicaid recipients receive these notices, all applications approved on or after October 13, 2005 must have a notice manually sent by the eligibility worker to any assistance group containing an adult age 21 or older, or an assistance group containing a dual eligible individual.

Notices must be sent on any application where Medicaid coverage is authorized for any month prior to January 1, 2006, including retroactive coverage requests.

Click here to view the Medicaid and DMA consumer notice

Click here to view the Dual Eligible consumer notice

Copies of the notices to consumers are available on the Ohio Health Plan website at http://innerweb/ohp/countyRes/. The eligibility worker may enter information into the notice forms online and print them. The CDJFS must send a copy of the appropriate notice to the Medicaid recipient and keep a copy for the case file. The date the notice was sent to the recipient and which type of notice sent must be documented in the case record.

The CDJFS will be notified via a view flash bulletin when these notices are made available in Spanish on the website.

New Policy: Changes to Medicaid and DMA Dental Coverage.

Starting January 1, 2006, Medicaid will no longer cover certain dental services for adults 21 years of age or older. This change is due to new state law and can be found in rules 5101:3-5-01 to 5101:3-5-11 and 5101:3-23-01 of the Ohio Administrative Code. Medicaid dental coverage will be limited to the following:

- One annual routine exam and cleaning,
- X-rays,
- Fillings,
- Simple extractions,
- Full and partial dentures,
- General anesthesia, and
- Anterior (front teeth) root canals.

Starting January 1, 2006, the DMA dental benefit will be limited to:

- Simple extractions, and
X-rays necessary to do the extractions.

**New Policy: Changes to Medicaid and DMA Co-Payments.**

Starting January 1, 2006, there may be a co-payment charge for Medicaid and DMA services, with some exceptions. This change is due to new state law and can be found in rules 5101:3-1-09 and 5101:3-23-01 of the Ohio Administrative Code. Co-payments may be charged for the following Medicaid and DMA services:

- Non-emergency services obtained in a hospital emergency room -- **$3 per visit.**
- Dental services -- **$3 per visit.**
- Routine eye examinations -- **$2 per examination.**
- Eyeglasses -- **$1 per fitting.**
- Most brand name (non-generic) medications -- **$2 per prescription or refill.**
- Prescription medication that requires prior authorization -- **will still remain $3 per prescription or refill.**

Individuals that cannot afford to pay their co-payment, at the time of services rendered, cannot be refused medical services. They will still be responsible to pay the co-payment at a later date and may be billed for it. A health care provider may refuse to provide services to a consumer with delinquent unpaid co-payments but must inform the individual, prior to refusing services, that this is the provider’s standard policy.

There are exceptions to the co-payment requirements. There is no co-payment attached to services if the patient is:

- Younger than 21, or
- Pregnant or her pregnancy ended within 90 days of service (does not apply to co-payments for routine eye examinations and eyeglass fittings), or
- Living in a nursing home or an intermediate care facility for the mentally retarded, or
- Getting emergency services in a hospital, clinic, office or other facility, or
- Getting services related to family planning, or
- Getting hospice care.

**New Policy: Changes to Medicaid Prescription Drug Coverage because of Medicare Part D.**

Starting January 1, 2006, individuals eligible for both Medicare and Medicaid (dual eligible) will have prescription drug coverage provided by Medicare. This change is due to new federal law and can be found in rules 5101:3-9-03, 5101:3-9-06 and 5101:3-9-12 of the Ohio Administrative Code. A letter will be sent from the federal Centers for Medicare and Medicaid Services at the end of October informing the dual eligible of the Prescription Drug Plan (PDP) that they have been auto-enrolled into and informing them of the assigned co-payments per prescription or refill.

Medicaid will still pay for some prescription drugs that will not be covered by Medicare, such as vitamins, cough suppressants, benzodiazepines and barbiturates. Medicaid will also pay for some over-the-counter medicines that do not have a prescription drug equivalent that is covered by Medicare. A co-payment may still apply to a prescription provided by Medicaid.

This change will only apply to the Medicaid prescription drug coverage for those individuals eligible for both Medicare and Medicaid. Medicaid will still provide coverage for other medical services for these dual eligible individuals.

The last day of Medicaid prescription drug coverage for dual eligible individuals will be December 31, 2005. Even though Medicare Part D is voluntary, if a dual eligible individual opts out of the Part D coverage they will not be entitled to Medicaid prescription drug coverage.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

**MEM Instructions:**
This MEPL is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/oheligibility/MEM

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 4
Medicaid Eligibility Procedure Letter No. 4

August 29, 2005

Effective Date: October 1, 2005
To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Standard Utility Allowance Increase

Reason for Change:
Ohio’s standard utility allowance in the Food Stamp program can be used in lieu of using individual utility expenses in determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the increase in the Food Stamp utility standard, the standard utility allowance for determination of the MMMNA is also being increased. The monthly income allowance (MIA) for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse’s monthly income.

Prior Policy: The standard utility allowance was $380.

New Policy: Effective October 1, 2005, the standard utility allowance of $380 is increased to $487.

Action Required:
With budgets that are effective October 1, 2005, the standard utility allowance of $487 shall be used when determining the community spouse’s monthly income allowance (MIA). A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2005 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E.

For reference purposes, the table shows the previous (2004) standard in parenthesis. The increased amount for 2005 is printed in bold.

<table>
<thead>
<tr>
<th>Standard Utility Allowance (SUA)</th>
<th>$487</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>($380-2004)</td>
</tr>
</tbody>
</table>

Effective October, 1, 2005, all new applicants must have eligibility determined using the utility standard of $487.

A CRIS-E View Flash Bulletin (CLVB) will be issued with this information. The new utility standard can be found on CRIS-E reference table TMEP.

MEM Instructions:
Action Change Transmittals

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTs</td>
<td>ACT No. 235 (Effective October 1, 2004)</td>
<td>MEPL No. 4 (Effective October 1, 2005)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:
Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/oheligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 3 (Increase in the NF average private pay rate)
Medicaid Eligibility Procedure Letter No. 3
July 20, 2005

Effective Date: September 1, 2005
OAC Rules: 5101:1-39-07 Medicaid: transfer of resources
5101:1-39-10 Medicaid: eligibility through the spenddown process
To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Increase in the average private pay rate for nursing facilities

Reason for Change: The Ohio Department of Aging has provided an updated average private pay rate for nursing facilities. Effective September 1, 2005, the average monthly private pay rate is $4806.

Prior Policy: The previous average private pay rate, last updated in 2003, was $4512.

New Policy: The updated average private pay rate for nursing facilities is $4806.

Action Required: A new period of restricted coverage is not computed for individuals currently in a penalty period. The CDJFS is not required to re-compute an improper transfer penalty period unless there is new information regarding the improper transfer (e.g., the resource was returned to the individual). The original notice that was issued to the applicant/recipient is still valid.

CRIS-E reference table TMEP has been updated to reflect this increase for recurring budgets effective September 1, 2005.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>MILs</td>
<td>MIL No. 03-007 (Effective July 1, 2003)</td>
<td>MEPL No. 3 (Effective September 1, 2005)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 2
Medicaid Eligibility Procedure Letter No. 2

June 20, 2005

Effective Date: July 1, 2005

To: All Medicaid Eligibility Manual Holders
From: Barbara E. Riley, Director
Subject: Medicaid: Income standard changes in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA)

Reason for Change:
Per federal requirements (42 USC 1396r-5 (d)(3)(A)) the MMMNA and ESA changes are effective with the second quarter following publication of the Federal Poverty Level (FPL). On February 18, 2005 the Department of Health and Human Services provided the updated FPL guidelines.

New Policy:
In accordance with the above reason for change, the following Medicaid income standards are affected by the increase in the FPL.
For reference purposes, this MEPL shows the previous (2004) standards in parenthesis. The increased amounts for 2005 are printed in bold.

<table>
<thead>
<tr>
<th>Minimum Monthly Maintenance Needs Allowance (MMMNA)</th>
<th>$1604 ($1562-2004)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$482 ($469-2004)</td>
</tr>
</tbody>
</table>

Action Required:
The MMMNA and ESA updates were not available in CRIS-E until May 24, 2005. Therefore, any application processed between May 20-23, 2005 must be re-evaluated to identify any impact on eligibility.
A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL. The new income standards can be found on CRIS-E reference table TMEP.

MEM Instructions:
Action Change Transmittals

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTs</td>
<td>ACT No. 233 (Effective July 1, 2004)</td>
<td>MEPL No. 2 (Effective July 1, 2005)</td>
</tr>
</tbody>
</table>

This MEPL is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
MEPL 1 (Household of another need standards)

Medicaid Eligibility Procedure Letter No. 1

June 20, 2005

Effective Date: January 1, 2005

OAC Rules: 5101:1-39-21

To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Medicaid:

- Issuance of the Medicaid Eligibility Procedure Letter (MEPL)
- "Household of another" need standards

This Medicaid Eligibility Procedure Letter serves two purposes. First, to introduce the new MEPL series, which will replace the designation of the Action Change Transmittal (ACT) and the Medicaid Information Letter (MIL).

The Medicaid Eligibility Procedure Letters are authored by the Medicaid Eligibility Policy Section to quickly relay policy changes or introduce a special project. MEPLs are used when it is required to communicate a change in policy prior to incorporating the change into the Medicaid Eligibility Manual. They are also used to notify of a policy change that does not originate in the department (e.g. federal poverty index). MEPLs are signed by the director, considered policy and must be implemented.

The second purpose is to include the Medicaid need standards for "individuals living in a household of another" and "couple living in household of another" that was inadvertently omitted from ACT 236.

Reason for Change: Annual adjustments in the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI.

Prior Policy: The table in this MEPL shows the increased 2005 standards for "individuals living in a household of another" and "couple living in household of another", benefits and or payment amounts.

New Policy: Effective January 1, 2005, a 2.7% increase in the CPI and COLA resulted in the adjustment of standards contained below:

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>(2004)</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual living in household of another</td>
<td>$327</td>
<td>$336</td>
</tr>
<tr>
<td>Couple living in household of another</td>
<td>$564</td>
<td>$579</td>
</tr>
</tbody>
</table>

This information was updated in the electronic eligibility system (CRIS-E), effective January 1, 2005, but was omitted in ACT 236 at the time of publication.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this MEPL.

This MEPL is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
Obsolete ACTs

The following Action Change Transmittal Letters are obsolete and are being provided for user convenience.
**ACT 239**

**Action Change Transmittal Letter No. 239**

March 14, 2005

Effective Date: April 1, 2005


TO: All Medicaid Eligibility Manual Holders

FROM: Barbara E. Riley, Director

SUBJECT: Medicaid: Income standard changes

**Reason for Change:** On February 18, 2005, the United States Department of Health and Human Services provided updated federal poverty level (FPL) guidelines.

**New Policy:** Income standards for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs will change effective April 1, 2005.

The following Medicaid income standards are affected by the increase in the FPL. The increased amounts for 2005 are in bold print.

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% of FPL</td>
<td>$798</td>
<td>$1070</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB) 120% of FPL</td>
<td>$957</td>
<td>$1283</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% of FPL</td>
<td>$1077</td>
<td>$1444</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI) 200% of FPL</td>
<td>$1595</td>
<td>$2139</td>
</tr>
</tbody>
</table>

**Action Required:** CRISE-E will complete a mass change effective April 1, 2005 to update MA-L and MAUS budgets to include the COLA increases on these cases. CDJFS must update budgets to include the COLA increases on these cases. Any assistance group denied or terminated for benefits effective April 1, 2005 due to the use of the previous income standards the CDJFS must redetermine eligibility using the current income standards published in this ACT.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT. The current income standards can be found on CRIS-E reference table TMEP.

This ACT is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
March 14, 2005

Effective Date: February 1, 2005

OAC Rule: 5101:1-40-26

TO: All Medicaid Eligibility Manual Holders

FROM: Barbara E. Riley, Director

SUBJECT: Income standard changes in Healthy Start, Healthy Families and Transitional Medicaid programs.

Reason for Change: On February 18, 2005, the United States Department of Health and Human Services provided updated federal poverty level (FPL) guidelines.

New Policy: Income standards for Healthy Start, Healthy Families and Transitional Medicaid programs have changed.

Effective February 1, 2005, the CDJFS must determine initial and ongoing eligibility for Healthy Start, Healthy Families and Transitional Medicaid using the following income standards:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Family 100%</th>
<th>Healthy Family 150%</th>
<th>Healthy Start 185%</th>
<th>Transitional 200%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$798.00</td>
<td>$1197.00</td>
<td>$1476.00</td>
<td>$1595.00</td>
</tr>
<tr>
<td>2</td>
<td>$1070.00</td>
<td>$1604.00</td>
<td>$1978.00</td>
<td>$2139.00</td>
</tr>
<tr>
<td>3</td>
<td>$1341.00</td>
<td>$2012.00</td>
<td>$2481.00</td>
<td>$2682.00</td>
</tr>
<tr>
<td>4</td>
<td>$1613.00</td>
<td>$2419.00</td>
<td>$2984.00</td>
<td>$3225.00</td>
</tr>
<tr>
<td>5</td>
<td>$1885.00</td>
<td>$2827.00</td>
<td>$3486.00</td>
<td>$3769.00</td>
</tr>
<tr>
<td>6</td>
<td>$2156.00</td>
<td>$3234.00</td>
<td>$3989.00</td>
<td>$4312.00</td>
</tr>
</tbody>
</table>

A report will be generated for each county identifying any assistance group denied or terminated for benefits effective February 1, 2005 due to the use of the previous income standards.

The current income standards are on CRIS-E reference table THST.

Mass change will not be run against Healthy Start and Healthy Family assistance groups. When ED/BC is requested for any case with these assistance groups, the correct income standard will appear on the budget screens.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT. This ACT is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.oddfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.oddfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.oddfs.state.oh.us/lpc/calendar/staff/
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
Action Change Transmittal Letter No. 237

December 22, 2004

Effective Date: January 1, 2005


To: All Medicaid Eligibility Manual Holders

From: Barbara E. Riley, Director

Subject: Spousal Impoverishment Standards Increase for 2005

Reason for Change:
Annual adjustments in the Spousal Impoverishment Standards due to the 2005 Cost of Living Adjustments.

New Policy:
The table in this ACT show the 2004 standards, benefits, and/or payment amounts with the increased amounts for 2005 in bold. These standards become effective January 1, 2005.

Spousal Impoverishment Standards:

<table>
<thead>
<tr>
<th>SPOUSAL IMPOVERISHMENT STANDARDS</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$18,552</td>
<td>$19,020</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$92,760</td>
<td>$95,100</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,319</td>
<td>$2,378</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance; excess shelter allowance and the family allowance will be revised effective July 1, 2005 based on the federal poverty level.

CRIS-E:
A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.
This ACT is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
ACT 236
Action Change Transmittal Letter No. 236

December 8, 2004

Effective Date: January 1, 2005


To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Consumer Price Index (CPI) Increase

2005 Cost of Living Adjustments (COLA)

Reason for Change:
Annual adjustments in the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI, Social Security, and Railroad Retirement benefits.

Increase in the Medicare Part B premium to $78.20 per month effective January 1, 2005.

Prior Policy:
The tables in this ACT show the 2004 standards, benefits, and/or payment amounts with the increased amounts for 2005 in bold.

New Policy:
Effective January 1, 2005, a 2.7% increase in the CPI and COLA affects the following standards, benefits and/or payments.

Social Security and Railroad Retirement Benefits:
Social Security benefits and Railroad Retirement benefits will increase by 2.7% effective January, 1 2005. The 2005 COLA increase for Social Security and Railroad Retirement benefits will be disregarded for QMB, SLMB, and QI-1 assistance groups for January, February and March 2005 only. These assistance groups must have the COLA applied in the financial eligibility determination effective April 1, 2005. For QMB/SLMB/Medicaid dual eligible assistance groups, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The CDJFS must enter the gross amount of all individual's Title II benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 2.7% COLA.

Note: In February 2005, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards effective April 1, 2005. Information regarding the necessary CDJFS activity for the April 2005 changes will be provided in another ACT.

SSI Increase:
The maximum payment amount will be:

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>$564</td>
<td>$579</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>$846</td>
<td>$869</td>
</tr>
</tbody>
</table>

Note: the $30 SSI maximum payment to institutionalized individuals will remain the same,

RSS Assistance Groups:
The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS assistance groups.

### DISREGARD OF SSI COLA INCREASE

<table>
<thead>
<tr>
<th></th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>

### Medicare Premium:

#### MEDICAID PART B PREMIUM

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B Premium</td>
<td>$66.60</td>
<td>$78.20</td>
</tr>
</tbody>
</table>

### Medicaid Need Standard:

#### MEDICAID NEED STANDARDS

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>$490</td>
<td>$504</td>
</tr>
<tr>
<td>Couple living in own household</td>
<td>$846</td>
<td>$869</td>
</tr>
</tbody>
</table>

### Special Income Level:

#### SPECIAL INCOME LEVEL

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>$1692</td>
<td>$1737</td>
</tr>
</tbody>
</table>

### Special Maintenance Needs Allowance:

#### SPECIAL MAINTENANCE NEEDS ALLOWANCE

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine HCBS waiver patient liability</td>
<td>$1101</td>
<td>$1131</td>
</tr>
</tbody>
</table>

### Spousal Impoverishment Standards:

#### SPOUSAL IMPOVERISHMENT STANDARDS

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Minimum community spouse resource allowance | $18,132 | $18,552
Maximum community spouse resource allowance | $90,660 | $92,760
Maximum monthly maintenance needs allowance (Cap) | $2,267 | $2,319

Note: The minimum monthly maintenance needs allowance; excess shelter allowance and the family allowance will be revised effective July 1, 2005 based on the federal poverty level.

**Action Required:**

**Long Term Care Facility (LTCF) Assistance Groups:**

Instructions for determining any change in the patient liability for LTCF assistance groups are explained in Public Assistance Letter (PAL) No. 868-A dated December 24, 1996.

After the mass change is run, ODJFS will issue two reports to the CDJFS. The first report (BON003-R001) identifies each Medicaid individual who resides in a LTCF. This report is for CDJFS information only. The second report (BON003-R002) is a summary of all individuals by LTCF. This report can be annotated and sent to the LTCF.

The cutoff date for prior notice is December 17, 2004. Any adverse notices regarding an increase in the patient liability after that date are to be effective February 1, 2005. **Retroactive adjustments for periods prior to the expiration of the prior notice of an increase in the patient liability are not correct and are not to be authorized.**

**CRIS-E:**

CRIS-E performed a mass change over the weekend of November 26, 2004 to update SSI, Social Security and Railroad Retirement COLA increases, the increased Medicaid need standards and Medicare Part B premium effective January 1, 2005.

CRIS-E will generate appropriate notice to cases updated by the mass change.

To the extent possible, the CDJFS should authorize pending assistance groups prior to the mass change. Otherwise the mass change action will by-pass them.

The CDJFS must provide appropriate notice to assistance groups bypassed during mass change in accordance with OAC 5101:6-2-04.

CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 assistance groups until the cutoff for April 2005 benefits.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.

This ACT is also available on the Internet and may be accessed at:

**Medicaid Eligibility Manual (MEM)**
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

**ODJFS Electronic Manuals**
http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**
http://www.odjfs.state.oh.us/lpc/calendar/
ACT 235
Action Change Transmittal Letter No. 235
September 20, 2004

Effective Date: October 1, 2004
OAC Rule: 5101:1-39-22.1
To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Standard Utility Allowance Increase

Reason for Change: Per federal requirements (42 USC 1396r-5 (d)(4)(B)) Ohio’s standard utility allowance in the Food Stamp program can be used in lieu of using individual utility expenses in determining the minimum monthly maintenance needs allowance (MMMNA) for a community spouse when the other spouse is considered institutionalized. As a result of the increase in the Food Stamp utility standard, the standard utility allowance for determination of the MMMNA is also being increased.

Prior Policy: The standard utility allowance was $360.

New Policy: Effective October 1, 2004, the standard utility allowance of $360 is being increased to $380.

Action Required: With budgets that are effective October 1, 2004, the standard utility allowance of $380 shall be used when determining the community spouse's monthly income allowance (MIA). A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2004 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E.

For reference purposes, this ACT shows the previous (2003) standard in parenthesis. The increased amount for 2004 is printed in bold.


Effective October, 1, 2004, all new applicants must have eligibility determined using the utility standard of $380.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT. The new utility standard can be found on CRIS-E reference table TMEP.

MEM Instructions:

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTs</td>
<td>ACT No. 226 (Effective October 1, 2004)</td>
<td>ACT No. 235 (Effective October 1, 2004)</td>
</tr>
</tbody>
</table>

Action Change Transmittals

Information is also available on the Internet and may be accessed at:

Medicaid Eligibility Manual (MEM)
http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM

ODJFS Electronic Manuals
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
ACT 233

Action Change Transmittal Letter No. 233

To be obsolete effective July 1, 2005.

June 8, 2004

Effective Date: July 1, 2004


TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: Medicaid: Income standard changes in the Minimum Monthly Maintenance Needs Allowance (MMMNA) and Excess Shelter Allowance (ESA)

Reason for Change:

Per federal requirements (42 USC 1396r-5 (d)(3)(A)) the MMMNA and ESA changes are effective with the second quarter following publication of the Federal Poverty Level (FPL). On February 13, 2004, the Department of Health and Human Services provided the updated federal poverty level (FPL) guidelines.

New Policy:

In accordance with the above reason for change, the following Medicaid income standards are affected by the increase in the FPL.

For reference purposes, this ACT shows the previous (2003) standards in parenthesis. The increased amounts for 2004 are printed in bold.

<table>
<thead>
<tr>
<th>Minimum Monthly Maintenance Needs Allowance (MMMNA)</th>
<th>$1562</th>
</tr>
</thead>
<tbody>
<tr>
<td>($1515 - 2003)</td>
<td></td>
</tr>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$469</td>
</tr>
<tr>
<td>($455 - 2003)</td>
<td></td>
</tr>
</tbody>
</table>

Action Required:

A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed. The CDJFS must recalculate the community spouse's Monthly Income Allowance (MIA) using the above allowances. These cases (MA-M) can be identified utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT. The new income standards can be found on CRIS-E reference table TMEP.

MEM Instructions:

**Action Change Transmittals**

<table>
<thead>
<tr>
<th>Location</th>
<th>Remove</th>
<th>Replace</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTs</td>
<td>ACT No. 225 (Effective July 1, 2003)</td>
<td>ACT No. 233 (Effective July 1, 2004)</td>
</tr>
</tbody>
</table>

This ACT is also available on the Internet and may be accessed at:

The ODJFS Electronic Manuals (previously known as dynaweb) has moved.

Please update your Bookmarks/Favorites in your Internet browser:
http://emanuals.odjfs.state.oh.us/emanuals
InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
ACT 230
Action Change Transmittal Letter No. 230

January 2, 2004

Effective Date: January 1, 2004
To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Increase in Student Child Earned Income Exclusion

Reason for Change: Effective January 1, 2004 the Consumer Price Index will increase by 2.1% which affects the amount of income that can be excluded from a student child's earned income.

Prior Policy: For a blind or disabled child who is a student regularly attending school, earned income up to $1,290 per month but not more than $5,200 in a calendar year is excluded.

New Policy: Effective January 1, 2004 up to $1,370 per month but not more than $5,520 in a calendar year is excluded from the earned income of a blind or disabled child who is a student regularly attending school.

This exclusion applies consecutively to months in which there is earned income until the exclusion is exhausted or the individual becomes age 18. This exclusion applies only to a student child's own income and applies only to a student child who is not institutionalized or enrolled in a home and community-based services (HCBS) waiver.

CRIS-E table TMEP has been updated and a CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.

This ACT is also available on the Internet and may be accessed at:
The ODJFS Electronic Manuals (previously known as dynaweb) has moved.
Please update your Bookmarks/Favorites in your Internet browser:
http://emanuals.odjfs.state.oh.us/emanuals

InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
ACT 231
Action Change Transmittal Letter No. 231

March 3, 2004

Effective Date: February 1, 2004
OAC Rule: 5101:1-40-26
To: All Medicaid Eligibility Manual Holders
From: Thomas J. Hayes, Director
Subject: Medicaid: Change in Healthy Start and Healthy Families income standards

Reason for Change:
The Department of Health and Human Services (HHS) has updated the federal poverty level (FPL) guidelines.

New Policy:
The Healthy Start and Healthy Families income standards are being increased by the change in the FPL.

CDJFS Activities:
Effective February 1, 2004, the CDJFS must determine initial and ongoing eligibility for Healthy Start and Healthy Families using the following income standards:

<table>
<thead>
<tr>
<th>Family</th>
<th>Healthy Family</th>
<th>Healthy Start</th>
<th>Healthy Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>100%</td>
<td>150%</td>
<td>200%</td>
</tr>
<tr>
<td>1</td>
<td>776.00</td>
<td>1,164.00</td>
<td>1,552.00</td>
</tr>
<tr>
<td>2</td>
<td>1,041.00</td>
<td>1,562.00</td>
<td>2,082.00</td>
</tr>
<tr>
<td>3</td>
<td>1,306.00</td>
<td>1,959.00</td>
<td>2,612.00</td>
</tr>
<tr>
<td>4</td>
<td>1,571.00</td>
<td>2,357.00</td>
<td>3,142.00</td>
</tr>
<tr>
<td>5</td>
<td>1,836.00</td>
<td>2,754.00</td>
<td>3,672.00</td>
</tr>
<tr>
<td>6</td>
<td>2,101.00</td>
<td>3,152.00</td>
<td>4,202.00</td>
</tr>
</tbody>
</table>

The CDJFS must use the income standards contained in this ACT to determine eligibility for Healthy Start and Healthy Families. The CDJFS must redetermine eligibility using the current income standards for any Healthy Start, Healthy Families, and Transitional Medicaid assistance groups denied or terminated on or after December 19, 2003 for benefits to be effective February 1, 2004.

To assist the CDJFS' a report will be generated for each county identifying MA-C, MA-P and MA-Y assistance groups that were denied benefits for February 2004 due to income in excess of the applicable standard.

The current income standards can be found on CRIS-E reference table THST.

Mass change will not be run against Healthy Start and Healthy Family assistance groups. When ED/BC is requested for any case with these assistance groups, the correct income standard will appear on the budget screens.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.
This ACT is also available on the Internet and may be accessed at:
The **ODJFS Electronic Manuals** (previously known as dynaweb) has moved. Please update your Bookmarks/Favorites in your Internet browser:

http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
March 3, 2004

Effective Date: April 1, 2004


TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: Medicaid: Income standard changes in the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individuals-1 (QI-1), and Qualified Working Disabled Individuals (QWDI) Medicaid programs.

Reason for Change:
On February 13, 2004, the Department of Health and Human Services provided the updated federal poverty level (FPL) guidelines.

New Policy:
The following Medicaid income standards are affected by the increase in the FPL. For reference purposes, this ACT shows the previous (2003) standards in parenthesis. The increased amounts for 2004 are printed in bold.

<table>
<thead>
<tr>
<th>Program</th>
<th>Single</th>
<th>Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Medicare Beneficiary (QMB) 100% of FPL</td>
<td>$776</td>
<td>$1041</td>
</tr>
<tr>
<td>Specified Low-Income Medicare Beneficiary (SLMB) 120% of FPL</td>
<td>$931</td>
<td>$1249</td>
</tr>
<tr>
<td>Qualified Individuals-1 (QI-1) 135% of FPL</td>
<td>$1048</td>
<td>$1406</td>
</tr>
<tr>
<td>Qualified Working Disabled Individual (QWDI) 200% of FPL</td>
<td>$1552</td>
<td>$2082</td>
</tr>
</tbody>
</table>

Action Required:
The exemption of the January 1, 2004 cost-of-living adjustment (COLA) received by QMB, SLMB, QI-1 and QWDI assistance groups ceases effective April 1, 2004. CRISE-E will complete a mass change effective April 1, 2004 to update MA-L and MAUS budgets to include the COLA increases on these cases.

When the CDJFS becomes aware of any assistance group denied or terminated for benefits effective April 1, 2004 due to the use of the previous income standards the CDJFS must redetermine eligibility using the current income standards published in this ACT.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT. The current income standards can be found on CRIS-E reference table TMEP.

This ACT is also available on the Internet and may be accessed at: The ODJFS Electronic Manuals (previously known as dynaweb) has moved.

Please update your Bookmarks/Favorites in your Internet browser:
http://emanuals.odjfs.state.oh.us/emanuals
InnerWeb Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/staff/

Internet Calendar:
http://www.odjfs.state.oh.us/lpc/calendar/
ACT 229A

Action Change Transmittal Letter No. 229-A

January 2, 2004

EFFECTIVE DATE: January 1, 2004


TO: All Medicaid Eligibility Manual Holders

FROM: Thomas J. Hayes, Director

SUBJECT: MEDICAID: CORRECTION TO ACTION CHANGE TRANSMITTAL LETTER NUMBER 229

Reason for Change: The figures reported in ACT 229 are incorrect.

New Policy: The corrected standards effective January 1, 2004 are as follows:

<table>
<thead>
<tr>
<th>SPOUSAL IMPOVERISHMENT STANDARDS</th>
<th>(2003)</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$18,132</td>
<td>$18,552</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$90,660</td>
<td>$92,760</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,267</td>
<td>$2,319</td>
</tr>
</tbody>
</table>

Action Required: Effective with applications received on or after January 1, 2004 the CDJFS shall apply the corrected standards set forth in this act when determining a community spouse resource allowance and minimum monthly maintenance needs allowance.

CRIS-E table TMEP has been updated and a CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.

This ACT is also available on the Internet and may be accessed at:

http://emanuals.odjfs.state.oh.us/emanuals

**InnerWeb Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/
TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: CONSUMER PRICE INDEX (CPI) INCREASE

EFFECTIVE DATE: January 1, 2004

2004 COST OF LIVING ADJUSTMENTS (COLA):

Reason for Change:
Annual adjustments in the Consumer Price Index (CPI) and Social Security cost-of-living adjustment (COLA) for SSI, Social Security, and Railroad Retirement benefits.
Increase in the Medicare Part B premium to $66.60 per month effective January 1, 2004.

Prior Policy:
The tables in this ACT show the 2003 standards, benefits, and/or payment amounts in parentheses and the increased amounts for 2004 in bold.

New Policy:
Effective January 1, 2004, a 2.1% increase in the CPI and COLA affects the following standards, benefits and/or payments:

Social Security and Railroad Retirement Benefits:
Social Security benefits and Railroad Retirement benefits will increase by 2.1% effective January 1, 2004.
The 2004 COLA increase for Social Security and Railroad Retirement benefits will be disregarded for QMB, SLMB, and QI-1 assistance groups for January, February, and March 2004 only. These assistance groups must have the COLA applied in the financial eligibility determination effective April 1, 2004. For QMB/SLMB/Medicaid dually eligible assistance groups, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The CDJFS must enter the gross amount of an individual's Title II benefits on CRIS-E screen AEFMI. CRIS-E will deduct the 2.1% COLA.
Note: In February 2004, the federal poverty level (FPL) will increase. This will cause an increase in the QMB, SLMB, and QI-1 standards effective April 1, 2004. Information regarding the necessary CDJFS activity for the April 2004 change will be provided in another ACT.

SSI Increase:
The maximum payment amount will be:

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>(2003)</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>($552)</td>
<td>$564</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>($829)</td>
<td>$846</td>
</tr>
</tbody>
</table>

Note: The $30 SSI maximum payment to institutionalized individuals will remain the same.

RSS Assistance Groups:
The SSI COLA increase is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS assistance groups:

<table>
<thead>
<tr>
<th>DISREGARD OF SSI COLA INCREASE</th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>

**Medicare premium:**

| MEDICAID PART B PREMIUM               | (2003) ($58.70) | 2004 $66.60 |

**Medicaid need standards:**

| MEDICAID NEED STANDARDS               | (2003)          | 2004 |
|---------------------------------------|-----------------|
| Individual in own household          | ($479)          | $490 |
| Couple living in own household       | ($829)          | $846 |

**Special income level:**

| SPECIAL INCOME LEVEL                  | (2003)          | 2004 |
|---------------------------------------|-----------------|
| Institutionalized/HCBS waiver         | ($1656)         | $1692 |

**Special Maintenance Needs Allowance:**

| SPECIAL MAINTENANCE NEEDS ALLOWANCE   | (2003)          | 2004 |
|---------------------------------------|-----------------|
| Special individual maintenance needs allowance used to determine HCBS waiver patient liability | ($1078)         | $1101 |

**Spousal Impoverishment Standards:**
<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>$18,132</td>
<td>$18,513</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>$90,660</td>
<td>$92,564</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (Cap)</td>
<td>$2,267</td>
<td>$2,315</td>
</tr>
</tbody>
</table>

Note: The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2004 based on the federal poverty level.

**Action Required:**

**Long Term Care Facility (LTCF) Assistance Groups:**

Instructions for determining any change in the patient liability for LTCF assistance groups are explained in Public Assistance Letter (PAL) No. 868-A dated December 24, 1996.

After the mass change is run, ODJFS will issue two reports to the CDJFS. The first report (BON003-R001) identifies each Medicaid individual who resides in a LTCF. This report is for CDJFS information only. The second report (BON003-R002) is a summary of all individuals by LTCF. This report can be annotated and sent to the LTCF.

The cutoff date for prior notice is December 15, 2003. Any adverse notices regarding an increase in the patient liability after that date are to be effective February 1, 2004. **Retroactive adjustments for periods prior to the expiration of the prior notice of an increase in the patient liability are not correct and are not to be authorized.**

**CRIS-E:**

CRIS-E will perform a mass change over the weekend of November 28, 2003 to update SSI, Social Security, and Railroad Retirement COLA increases, the increased Medicaid need standards and Medicare Part B premium effective January 1, 2004.

CRIS-E will generate appropriate notice to cases updated by the mass change.

To the extent possible, the CDJFS should authorize pending assistance groups prior to the mass change. Otherwise, the mass change action will by-pass them.

CRIS-E does not automatically perform a mass change for cases in fiated status or assistance groups with a spenddown liability.

CRIS-E will send Alerts for all assistance groups that were bypassed by mass change.

The CDJFS must provide appropriate notice to assistance groups bypassed during mass change in accordance with OAC 5101:6-2-04.

CRIS-E will disregard the COLA increases for QMB, SLMB, and QI-1 assistance groups until the cutoff for April 2004 benefits.

This ACT is also available on the Internet and may be accessed at:

http://dynaweb.odjfs.state.oh.us:6336/dynaweb/ohpeligibility/MEM.

**InnerWeb Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/staff/

**Internet Calendar:**

http://www.odjfs.state.oh.us/lpc/calendar/

**Instructions:**

EFFECTIVE DATE: October 1, 2003
OAC RULE: 5101:1-39-22.1

TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: MEDICAID: STANDARD UTILITY ALLOWANCE INCREASE

Reason for Change: The standard utility allowance is being increased as a result of the increase in the food stamp utility standard.

Prior Policy: The standard utility allowance was $306.

New Policy: Effective October 1, 2003, the standard utility allowance of $306 is being increased to $360.

Action Required: Effective October 1, 2003, the standard utility allowance of $360 shall be used when determining the community spouse's monthly income allowance (MIA). A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed prior to the October 1, 2003 cutoff to ensure the new increased standard is applied appropriately. The CDJFS must recalculate the MIA using the increased utility allowance. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E.

Effective October, 1, 2003, all new applicants must have eligibility determined using the utility standard of $360.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.
EFFECTIVE DATE: July 1, 2003
OAC RULES: 5101:1-39-22.1

TO: All Medicaid Eligibility Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: MEDICAID: INCREASE IN THE MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA), FAMILY ALLOWANCE (FA) AND EXCESS SHELTER ALLOWANCE (ESA)

Reason for Change: Under the Social Security Act’s spousal impoverishment provisions the following Medicaid standards will increase effective July 1, 2003 based on the change in the federal poverty level (FPL).

New Policy: For reference purposes, this ACT shows the previous (2002) allowances.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Allowance (FA) 1/3 of MMMNA</td>
<td>$498</td>
<td>$505</td>
</tr>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$448</td>
<td>$455</td>
</tr>
</tbody>
</table>

Action Required: A review of all long term care facility (LTCF) and home and community-based services (HCBS) waiver assistance groups with a community spouse must be completed. The CDJFS must recalculate the community spouse’s Monthly Income Allowance (MIA) and Family Allowance (FA) using the above allowances. These cases (MA-M) can be identified by utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E.

A CRIS-E View Flash Bulletin (CLVB) will be issued with the information contained in this ACT.

This information is also available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/oheligibility/MEM
March 14, 2003

EFFECTIVE DATE: April 1, 2003
TO: All Public Assistance Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: MEDICAID: CHANGES IN MEDICAID NEED STANDARDS DUE TO 2003 FEDERAL POVERTY LEVEL INCREASE

On February 7, 2003, the Department of Health and Human Services provided the updated federal poverty level (FPL) guidelines which are being increased due to the price increase as measured by the Consumer Price Index. The following Medicaid standards and allowance are affected by these changes:

1) Qualified Medicare Beneficiary (QMB)
2) Specified Low-Income Medicare Beneficiary (SLMB)
3) Qualified Individuals-1 (QI-1)
4) Qualified Working Disabled Individual (QWDI)

For reference purposes, this ACT shows the previous 2002 standards and allowances in parenthesis. The increased amounts for 2003 are printed in bold.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SINGLE</th>
<th>COUPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUALIFIED MEDICARE BENEFICIARY (QMB) 100% of FPL</td>
<td>$749</td>
<td>$1010</td>
</tr>
<tr>
<td>SPECIAL LOW-INCOME MEDICARE BENEFICIARY (SLMB) 120% of FPL</td>
<td>$899</td>
<td>$1212</td>
</tr>
<tr>
<td>QUALIFIED INDIVIDUALS-1 (QI-1) 135% of FPL</td>
<td>$1012</td>
<td>$1364</td>
</tr>
<tr>
<td>QUALIFIED WORKING DISABLED INDIVIDUAL (QWDI) 200% of FPL</td>
<td>$1498</td>
<td>$2020</td>
</tr>
</tbody>
</table>

**ACTION REQUIRED:**

- The exemption of the January 1, 2003 cost-of-living increases received by QMB, SLMB, QI-1, and QWDI assistance groups ceases effective April 1, 2003. CRIS-E will complete a mass change effective April 1, 2003 to update MA-L and MAUS budgets to include the COLA increases on these cases.

- If the CDJFS becomes aware of any assistance group denied or terminated due to the use of the previous need standards and allowances which have been increased in this ACT, the CDJFS shall redetermine eligibility using the current need standards and allowances. Adverse actions cannot be implemented until the CDJFS provides appropriate notice in accordance with Chapter 5101:6-2 of the Ohio Administrative Code (OAC).

**INSTRUCTIONS**
Medicare Premium Assistance Program Standards dated 4/2003, replace appendix B that was previously part of the Public Assistance Manual.

This ACT is also available on the Internet and may be accessed at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/oheligibility/MEM. You can also access new issuances of policy at Legal/Policy Central calendar which is available on the ODJFS InnerWeb at: http://www.state.oh.us/odjfs/lpc/calendar/staff and on the Internet at: http://www.state.oh.us/odjfs/lpc/calendar/. The calendar provides a daily list of policy letters with links to the electronic manuals and to printable (PDF) versions.
TO: All Medicaid Eligibility Manual Holders  
FROM: Thomas J. Hayes, Director  
SUBJECT: MEDICAID: CHANGE IN HEALTHY START, HEALTHY FAMILIES NEED STANDARD DUE TO FEDERAL POVERTY LEVEL INCREASES  

Background:  
The Department of Health and Human Services (HHS) updates federal poverty level (FPL) guidelines annually to account for the previous calendar year’s increase in the consumer price Index.  

Current Action:  
On February 7, 2003, HHS issued the updated federal poverty level (FPL) guidelines. The Healthy Start and Healthy Families standards are affected by this change.  

CDJFS Activities:  
Effective February 1, 2003, the CDJFS shall determine initial and ongoing eligibility for Healthy Start and Healthy Families using the following standards.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Healthy Family 100%</th>
<th>Healthy Start 150%</th>
<th>Healthy Start 200%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>749.00</td>
<td>1,123.00</td>
<td>1,497.00</td>
</tr>
<tr>
<td>2</td>
<td>1,010.00</td>
<td>1,515.00</td>
<td>2,020.00</td>
</tr>
<tr>
<td>3</td>
<td>1,272.00</td>
<td>1,908.00</td>
<td>2,544.00</td>
</tr>
<tr>
<td>4</td>
<td>1,534.00</td>
<td>2,300.00</td>
<td>3,067.00</td>
</tr>
<tr>
<td>5</td>
<td>1,795.00</td>
<td>2,693.00</td>
<td>3,590.00</td>
</tr>
<tr>
<td>6</td>
<td>2,057.00</td>
<td>3,085.00</td>
<td>4,114.00</td>
</tr>
</tbody>
</table>

The CDJFS shall use the current standards contained in this MEL to determine eligibility for Healthy Start and Healthy Families. If the CDJFS becomes aware of any Healthy Start or Healthy Families assistance groups denied or terminated due to the use of the previous standards, the CDJFS shall determine eligibility using the current needs standards. The current need standards can be found on CRIS-E reference table THST.  

Mass change will not be run against Healthy Start, Healthy Family assistance groups. When ED/BC is requested for any case with these assistance groups, the correct standard will appear on the budget screens. The CDJFS shall rerun any cases, which were inappropriately denied due to the use of the previous standards.
ACT 220
Action Change Transmittal Letter No. 220

November 29, 2002

EFFECTIVE DATE: January 1, 2003


TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: Thomas J. Hayes, Director

SUBJECT: 2003 SOCIAL SECURITY COST OF LIVING ADJUSTMENTS (COLA)

SUPPLEMENTAL SECURITY INCOME (SSI) BENEFIT INCREASE

SOCIAL SECURITY BENEFIT INCREASE

RAILROAD RETIREMENT BENEFIT INCREASE

MEDICARE PART B PREMIUM INCREASE

SPOUSAL IMPOVERISHMENT STANDARDS

Effective January 1, 2003 there is a 1.4% cost-of-living adjustment (COLA) for SSI, Social Security, and Railroad Retirement benefits. The Medicare Part B premium is also increasing to $58.70 per month. For reference, this ACT shows the previous (2002) standards and payment amounts in parenthesis as well as the increased amounts for 2003 which are printed in bold.

**SSI Increase:**

For SSI, the $30 payment to institutionalized individuals will remain the same. The benefit amounts, including increases for other individuals will be:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>($545)</td>
<td>$552</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>($817)</td>
<td>$829</td>
</tr>
</tbody>
</table>

The reduced payment amounts for SSI individuals and couples living in the home of another are no longer included in this chart. SSI continues to use a retrospective budgeting method in computing monthly benefit payments.

**Medicare premium:**

MEDICARE PART B PREMIUM ($54.00/2002) $58.70 / 2003

**Medicaid need standards:**

Effective January 1, 2003 the Medicaid need standards are increased as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>($472)</td>
<td>$479</td>
</tr>
</tbody>
</table>
Couple living own household | ($817) | $829

**Special income level:**

<table>
<thead>
<tr>
<th>SPECIAL INCOME LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
</tr>
</tbody>
</table>

PAM Chapter 7000 (Appendix D) has been updated to reflect this change.

**Home and Community-Based Services (HCBS) Waivers:**

<table>
<thead>
<tr>
<th>HOME AND COMMUNITY-BASED SERVICES WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine patient liability</td>
</tr>
</tbody>
</table>

**Disregard of Title II COLA:**

The Title II COLA is disregarded for QMB, SLMB, QI-1 and QI-2 assistance groups for January, February, and March 2003 only. These assistance groups shall have the COLA applied in the financial eligibility determination effective April 1, 2003. For QMB/SLMB/Medicaid dually eligible assistance groups, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The gross amount of an individual’s Title II benefits should be entered on AEFMI. CRIS-E will deduct the 1.4% COLA.

In February 2003, the federal poverty level (FPL) will be increased. This will cause an increase in the QMB, SLMB, QI-1 and QI-2 standards effective April 1, 2003. Information regarding the necessary CDJFS activity for the April 2003 change will be provided in the near future.

**RSS Assistance Groups:**

The SSI COLA is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS assistance groups:

<table>
<thead>
<tr>
<th>PASS-ALONG OF SSI COLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum SSI benefit</td>
</tr>
</tbody>
</table>

PAM Chapter 6000 (OAC 5101:1-17-07) will be updated in a future Manual Transmittal Letter.

**Increase in Spousal Impoverishment Standards:**

The Consumer Price Index (CPI) will increase by 1.5%. Effective January 1, 2003 the following spousal impoverishment standards are increased as follows:

<table>
<thead>
<tr>
<th>Spousal Impoverishment Standards are increased as follows:</th>
</tr>
</thead>
</table>
The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2002 based on the federal poverty level.

**Black Lung Benefit Increase:**
The Black Lung benefit is anticipated to increase effective February 2003; however, the percentage of increase is not available at this time. Information regarding the Black Lung benefit increase and necessary CDJFS activity will be provided as soon as the percentage of increase is available.

**CRIS-E:**
CRIS-E will perform a mass change over the weekend of November 22, 2002 to update SSI, Social Security, and Railroad Retirement cost-of-living increases and the increased Medicaid need standards effective January 1, 2003. The $30 SSI payment to institutionalized individuals remains the same.

To the extent possible, pending assistance groups should be authorized prior to the mass change. Otherwise, the mass change action will by-pass them. CRIS-E does not automatically perform a mass change for cases in fliated status or assistance groups with spenddown amounts.

CRIS-E will disregard the COLA increases for QMB, SLMB, QI-1 and QI-2 assistance groups until the cutoff for April 2003 benefits.

CRIS-E ALERTS will be sent for all assistance groups that were bypassed by mass change.

**LTCF Assistance Groups:**
Instructions for redetermining any change in the patient liability for LTCF assistance groups are explained in Public Assistance Letter (PAL) No. 868-A dated December 24, 1996.

Two reports will be issued to the CDJFS. The first report (BON003-R001) identifies each individual who resides in a long term care facility. This report is for CDJFS information only. The second report (BON003-R002) is a summary of all individuals by LTCF. This report can be annotated and sent to the LTCF.

The cutoff for prior notice is December 18, 2002. Any adverse notices regarding an increase in the patient liability after that date are to be effective February 1, 2003.

**Prior Notice of Adverse Action:**
All assistance groups adversely affected by the increased benefit amounts shall be provided with written notice of the proposed action. CRIS-E cases updated by the mass change shall be provided appropriate notice through a computer-generated notice. Assistance groups bypassed during mass change shall be provided appropriate notice from the CDJFS in accordance with OAC 5101:6-2-04.

The JFS 04065, "Prior Notice of Right to a State Hearing," or appropriate CRIS-E notice shall contain the following language.

**THE REASON FOR THIS PROPOSED ACTION . . .** "This action is necessary because federal regulations have provided you, your spouse, or a family member with an increase in Supplemental Security Income (SSI), Social Security, or Railroad Retirement benefits. Public Assistance Manual Sections 7436 (5101:1-39-16), and 11000 (OAC 5101:1-40-20) require that this income be counted in determining eligibility for assistance."

An adverse action cannot be taken until 15 days have elapsed from the date of issuing the notice of adverse action. After the expiration of the 15-day prior notice period, the proposed action shall be implemented if a hearing on the proposed action is not requested.

If a hearing request is made within the 15-day prior notice period, assistance must continue until it is determined at the hearing that the sole issue is one of state policy or until the hearing decision is rendered. All appeals of adverse actions resulting from increased amounts must be forwarded to the State Hearings
Section. If assistance is continued during the pendency of the hearing and the decision is against the assistance group, a collectible overpayment may occur.

**Instructions:**
In the Appendix to Chapter 7000, remove and file as obsolete Appendices A (Rev. 1/02), C (Rev. 1/02) and D (7/02) and replace with the corresponding pages effective January 1, 2003 which are attached to this ACT. (Appendix A, Appendix C and Appendix D)

Obsolete the following ACTs: ACT 215, ACT 215-A.
ACT 218
Action Change Transmittal No. 218

June 7, 2002

EFFECTIVE DATE: July 1, 2002
OAC RULE: 5101:1-39-221

TO: All Public Assistance Manual Holders
FROM: Thomas J. Hayes, Director
SUBJECT: MEDICAID: INCREASE IN MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA), FAMILY ALLOWANCE (FA) AND EXCESS SHELTER ALLOWANCE (ESA)

Reason for change: Under the Social Security Act’s spousal impoverishment provisions, the following Medicaid standards have been increased effective July 1, 2002 based on the federal poverty level (FPL).

For reference purposes, this ACT shows the previous (2001) allowances in parentheses. The increased amounts for 2002 are printed in bold.

<table>
<thead>
<tr>
<th>Allowance Description</th>
<th>2001 Allowance</th>
<th>2002 Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Monthly Maintenance Needs Allowance (MMMNA)</td>
<td>$1,452</td>
<td>$1,493</td>
</tr>
<tr>
<td>Family Allowance (FA) 1/3 of MMMNA</td>
<td>$484</td>
<td>$498</td>
</tr>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$436</td>
<td>$448</td>
</tr>
</tbody>
</table>

Action required: A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed. The CDJFS must recalculate the community spouse's MIA using the above allowances. These cases (MA-M) can be identified utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E.

Remove and file as obsolete Appendix D and replace with Appendix D dated July 2002.
ACT 217A

Action Change Transmittal Letter No. 217a

March 27, 2002

EFFECTIVE DATE: February 1, 2002

OAC RULES: 5101:1-40-08, 5101:1-40-08.1, 5101:1-40-02.6

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: Thomas J. Hayes, Director

SUBJECT: CORRECTION TO MEDICAID: CHANGE IN HEALTHY START, HEALTHY FAMILIES NEED STANDARD DUE TO FEDERAL POVERTY LEVEL INCREASES

This transmittal is to correct a typographical error in the Healthy Start and Healthy Families 2002 Federal Poverty Level guidelines chart. The label introducing the 200% standard was incorrectly labeled Healthy Families and should be Healthy Start as noted below.

<table>
<thead>
<tr>
<th>100% Healthy Families Std.</th>
<th>150% Healthy Start Std.</th>
<th>200% Healthy Start Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. $739.00</td>
<td>1. $1108.00</td>
<td>1. $1477.00</td>
</tr>
<tr>
<td>2. 995.00</td>
<td>2. 1493.00</td>
<td>2. 1990.00</td>
</tr>
<tr>
<td>3. 1252.00</td>
<td>3. 1878.00</td>
<td>3. 2504.00</td>
</tr>
<tr>
<td>4. 1509.00</td>
<td>4. 2263.00</td>
<td>4. 3017.00</td>
</tr>
<tr>
<td>5. 1765.00</td>
<td>5. 2648.00</td>
<td>5. 3530.00</td>
</tr>
<tr>
<td>6. 2022.00</td>
<td>6. 3033.00</td>
<td>6. 4044.00</td>
</tr>
</tbody>
</table>
**ACT 217**  
Action Change Transmittal Letter No. 217  

March 19, 2002

**EFFECTIVE DATE:** February 1, 2002

**OAC RULES:** 5101:1-40-08, 5101:1-40-08.1, 5101:1-40-02.6

**TO:** ALL PUBLIC ASSISTANCE MANUAL HOLDERS

**FROM:** Thomas J. Hayes, Director

**SUBJECT:** MEDICAID: CHANGE IN HEALTHY START, HEALTHY FAMILIES NEED STANDARD DUE TO FEDERAL POVERTY LEVEL INCREASES

**Reason for change:** On February 14, 2002, the Department of Health and Human Services issued the updated federal poverty level (FPL) guidelines which are being increased due to the price increase as measured by the Consumer Price Index. The Healthy Start, Healthy Families standards are affected by this change.

**Prior policy:** Based on the 2001 FPL guidelines, the Healthy Start, Healthy Families are as follows:

<table>
<thead>
<tr>
<th>100% Healthy Families Std.</th>
<th>150% Healthy Start Std.</th>
<th>200% Healthy Families Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 $716.00</td>
<td>1 $1074.00</td>
<td>1 $1432.00</td>
</tr>
<tr>
<td>2 968.00</td>
<td>2 1452.00</td>
<td>2 1935.00</td>
</tr>
</tbody>
</table>

**New Policy:** Effective February 1, 2002, the CDJFS shall determine initial and ongoing eligibility for Healthy Start and Healthy Families using the following standards.

<table>
<thead>
<tr>
<th>100% Healthy Families Std.</th>
<th>150% Healthy Start Std.</th>
<th>200% Healthy Families Std.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. $739.00</td>
<td>1. $1108.00</td>
<td>1. $1477.00</td>
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</tr>
<tr>
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<td>3. 2504.00</td>
</tr>
<tr>
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<td>4. 2263.00</td>
<td>4. 3017.00</td>
</tr>
<tr>
<td>5. 1765.00</td>
<td>5. 2648.00</td>
<td>5. 3530.00</td>
</tr>
<tr>
<td>6. 2022.00</td>
<td>6. 3033.00</td>
<td>6. 4044.00</td>
</tr>
</tbody>
</table>

**Action Required:** Effective February 1, 2002, the CDJFS shall use the current standards contained in the ACT to determine eligibility for Healthy Start and Healthy Families. If the CDJFS becomes aware of any Healthy Start or Healthy Families assistance groups denied or terminated due to the use of the previous standards, the CDJFS shall determine eligibility using the current need standards. The current need standards can be found on CRIS-E reference table THST.

Mass change will not be run against Healthy Start, Healthy Family assistance groups. When ED/BC is requested for any case with these assistance groups, the correct standard will appear on the budget screens. The CDJFS shall rerun any cases which were inappropriately denied due to the use of the previous standards.
EFFECTIVE DATE: April 1, 2002

PAM CHAPTER: 7000


TO: All Public Assistance Manual Holders

FROM: Thomas J. Hayes, Director

SUBJECT: MEDICAID: CHANGES IN MEDICAID NEED STANDARDS DUE TO 2002 FEDERAL POVERTY LEVEL INCREASE

On February 14, 2002, the Department of Health and Human Services provided the updated federal poverty level (FPL) guidelines which are being increased due to the price increase as measured by the Consumer Price Index. The following Medicaid standards and allowance are affected by these changes:

1) Qualified Medicare Beneficiary (QMB)
2) Specified Low-Income Medicare Beneficiary (SLMB)
3) Qualified Individuals-1 (QI-1)
4) Qualified Individuals-2 (QI-2)
5) Qualified Working Disabled Individual (QWDI)

For reference purposes, this ACT shows the previous 2001 standards and allowances in parenthesis.

The increased amounts for 2002 are printed in bold.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SINGLE</th>
<th>COUPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUALIFIED MEDICARE BENEFICIARY (QMB) 100% of FPL</td>
<td>$739 ($716-2001)</td>
<td>$995 ($968-2001)</td>
</tr>
<tr>
<td>SPECIAL LOW-INCOME MEDICARE BENEFICIARY (SLMB) 120% of FPL</td>
<td>$886 ($859-2001)</td>
<td>$1194 ($1161-2001)</td>
</tr>
<tr>
<td>QUALIFIED INDIVIDUALS-1 (QI-1) 135% of FPL</td>
<td>$997 ($967-2001)</td>
<td>$1344 ($1307-2001)</td>
</tr>
<tr>
<td>QUALIFIED INDIVIDUAL-2 (QI-2) 175% of FPL</td>
<td>$1293 ($1253-2001)</td>
<td>$1742 ($1694-2001)</td>
</tr>
<tr>
<td>QUALIFIED WORKING DISABLED INDIVIDUAL (QWDI) 200% of FPL</td>
<td>$1477 ($1432-2001)</td>
<td>$1990 ($1935-2001)</td>
</tr>
</tbody>
</table>

**ACTION REQUIRED:**

1) The exemption of the January 1, 2002 cost-of-living increases received by QMB, SLMB, QI-1, and QI-2 and QWDI assistance groups ceases effective April 1, 2002. CRIS-E will complete a mass change effective April 1, 2002 to update MA-L and MAUS budgets to include the COLA increases on these cases.
2) If the CDJFS becomes aware of any assistance group denied or terminated due to the use of the previous need standards and allowances which have been increased in this ACT, the CDJFS shall redetermine eligibility using the current need standards and allowances. Adverse actions cannot be implemented until the CDJFS provides appropriate notice in accordance with Chapter 5101:6-2 of the Ohio Administrative Code (OAC).

INSTRUCTIONS
Remove and file as obsolete, in the appendix to Chapter 7000, Appendix B. Replace with the updated version of Appendix B.
ACT 215A
Action Change Transmittal Letter No. 215-A

March 1, 2002

OBSOLETE PER ACT 220

EFFECTIVE DATE: January 1, 2002

PAM CHAPTER/OAC: 7000

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: THOMAS J. HAYES, DIRECTOR

SUBJECT: 2002 SOCIAL SECURITY COST OF LIVING ADJUSTMENTS (COLA)

Reason for Change: It has come to our attention that the years listed in the Medicaid Need Standards chart in ACT 215 do not reflect the correct years for the change in the need standards.

New Policy: This ACT provides the correct years with the standards.

Medicaid Need Standards:

Effective January 1, 2002 the Medicaid need standards are increased as follows:

<table>
<thead>
<tr>
<th>MEDICAID NEED STANDARDS</th>
<th>(2001)</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>($460)</td>
<td>$472</td>
</tr>
<tr>
<td>Couple living own household</td>
<td>($796)</td>
<td>$817</td>
</tr>
<tr>
<td>Individual living in household of another</td>
<td>($307)</td>
<td>$315</td>
</tr>
<tr>
<td>Couple in household of another</td>
<td>($530)</td>
<td>$545</td>
</tr>
</tbody>
</table>

The standards in CRIS-E are correct. A desk review is not required to identify assistance groups that may be affected by this error. However, at the time of application, reapplication, case change, or when the CDJFS becomes aware that an assistance group may have been adversely affected by the use of the incorrect years, the CDJFS shall redetermine eligibility in accordance with this ACT.
TO:    ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM:  THOMAS J. HAYES, DIRECTOR
SUBJECT: 2002 SOCIAL SECURITY COST OF LIVING ADJUSTMENTS (COLA)

SUPPLEMENTAL SECURITY INCOME (SSI) BENEFIT INCREASE
SOCIAL SECURITY BENEFIT INCREASE
RAILROAD RETIREMENT BENEFIT INCREASE
MEDICARE PART B PREMIUM INCREASE
SPOUSAL IMPOVERISHMENT STANDARDS

Effective January 1, 2002 there is a 2.6% cost-of-living adjustment (COLA) for SSI, Social Security, and Railroad Retirement benefits. The Medicare Part B premium is also increasing to $54.00 per month. For reference, this ACT shows the previous (2001) standards and payment amounts in parenthesis as well as the increased amounts for 2002 which are printed in bold.

SSI Increase:
For SSI, the $30 payment to institutionalized individuals will remain the same. The benefit amounts, including increases for other individuals will be:

<table>
<thead>
<tr>
<th></th>
<th>(2001)</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>($530)</td>
<td>$545</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>($796)</td>
<td>$817</td>
</tr>
<tr>
<td>Supplement for an essential person in an independent living arrangement</td>
<td>($266)</td>
<td>$273</td>
</tr>
</tbody>
</table>

The reduced payment amounts for SSI individuals and couples living in the home of another are no longer included in this chart. SSI continues to use a retrospective budgeting method in computing monthly benefit payments.

Medicare premium:

MEDICARE PART B PREMIUM  ($50.00/2001)  $54.00 / 2002

Medicaid need standards:  (The hardcopy erroneously lists the dates as (2000) and 2001 in the table below, however the electronic version has been corrected)

Effective January 1, 2002 the Medicaid need standards are increased as follows:
### MEDICAID NEED STANDARDS

<table>
<thead>
<tr>
<th></th>
<th>(2001)</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
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<td>$315</td>
</tr>
<tr>
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<td>$545</td>
</tr>
</tbody>
</table>

### Special income level:

#### SPECIAL INCOME LEVEL

| Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household) | ($1590/2001) | $1635/2002 |

PAM Chapter 7000 (Appendix D) has been updated to reflect this change.

### Home and Community-Based Services (HCBS) Waivers:

#### HOME and COMMUNITY-BASED SERVICES WAIVERS

| Special individual maintenance needs allowance used to determine patient liability | ($1036/2001) | $1063/2002 |

### Disregard of Title II COLA:

The Title II COLA is disregarded for QMB, SLMB, QI-1 and QI-2 assistance groups for January, February, and March 2002 only. These assistance groups shall have the COLA applied in the financial eligibility determination effective April 1, 2002. For QMB/SLMB/Medicaid dually eligible assistance groups, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The gross amount of an individual's Title II benefits should be entered on AEFMI. CRIS-E will deduct the 2.6% COLA.

In February 2002, the federal poverty level (FPL) will be increased. This will cause an increase in the QMB, SLMB, QI-1 and QI-2 standards effective April 1, 2002. Information regarding the necessary CDJFS activity for the April 2002 change will be provided in the near future.

### RSS Assistance Groups:

The SSI COLA is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS assistance groups:

#### PASS-ALONG OF SSI COLA

<table>
<thead>
<tr>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>
PAM Chapter 6000 (OAC 5101:1-17-13) will be updated within a future Manual Transmittal Letter.

**Increase in Spousal Impoverishment Standards:**

The Consumer Price Index (CPI) will increase by 2.6%. Effective January 1, 2002 the following spousal impoverishment standards are increased as follows:

<table>
<thead>
<tr>
<th>Minimum community spouse resource allowance</th>
<th>($17,400 / 2001)</th>
<th>$17,856 / 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>($87,000 / 2001)</td>
<td>$89,280 / 2002</td>
</tr>
</tbody>
</table>

The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2002 based on the federal poverty level.

**Black Lung Benefit Increase:**

The Black Lung benefit is anticipated to increase effective February 2002; however, the percentage of increase is not available at this time. Information regarding the Black Lung benefit increase and necessary CDJFS activity will be provided as soon as the percentage of increase is available.

**CRIS-E:**

CRIS-E will perform a mass change over the weekend of November 26, 2001 to update SSI, Social Security, and Railroad Retirement cost-of-living increases and the increased Medicaid need standards effective January 1, 2002. The $30 SSI payment to institutionalized individuals remains the same.

To the extent possible, pending assistance groups should be authorized prior to the mass change. Otherwise, the mass change action will by-pass them. CRIS-E does not automatically perform a mass change for cases in fiated status or assistance groups with spenddown amounts.

CRIS-E will disregard the COLA increases for QMB, SLMB, QI-1 and QI-2 assistance groups until the cutoff for April 2002 benefits.

CRIS-E ALERTS will be sent for all assistance groups that were bypassed by mass change.

**LTCF Assistance Groups:**

Instructions for redetermining any change in the patient liability for LTCF assistance groups are explained in Public Assistance Letter (PAL) No. 868-A dated December 24, 1996.

Two reports will be issued to the CDJFS. The first report (BON003-R001) identifies each individual who resides in a long term care facility. This report is for CDJFS information only. The second report (BON003-R002) is a summary of all individuals by LTCF. This report can be annotated and sent to the LTCF.

The cutoff for prior notice is December 14, 2001. Any adverse notices regarding an increase in the patient liability after that date are to be effective February 1, 2002. **Retroactive adjustments for periods prior to the expiration of the prior notice of an increase in the patient liability are not correct and the CDJFSs are not authorized to initiate them.**

**Prior Notice of Adverse Action:**

All assistance groups adversely affected by the increased benefit amounts shall be provided with written notice of the proposed action. CRIS-E cases updated by the mass change shall be provided appropriate notice through a computer-generated notice. Assistance groups bypassed during mass change shall be provided appropriate notice from the CDJFS in accordance with OAC 5101:6-2-04.

The JFS 04065, "Prior Notice of Right to a State Hearing," or appropriate CRIS-E notice shall contain the following language.

**THE REASON FOR THIS PROPOSED ACTION . . .** "This action is necessary because federal regulations have provided you, your spouse, or a family member with an increase in Supplemental Security Income (SSI),

An adverse action cannot be taken until 15 days have elapsed from the date of issuing the notice of adverse action. After the expiration of the 15-day prior notice period, the proposed action shall be implemented if a hearing on the proposed action is not requested.

If a hearing request is made within the 15-day prior notice period, assistance must continue until it is determined at the hearing that the sole issue is one of state policy or until the hearing decision is rendered. All appeals of adverse actions resulting from increased amounts must be forwarded to the State Hearings Section. If assistance is continued during the pendency of the hearing and the decision is against the assistance group, a collectible overpayment may occur.

**Instructions:**

In the Appendix to Chapter 7000, remove and file as obsolete Appendices A (Rev. 1/01), C (Rev. 1/01) and D (7/01) and replace with the corresponding pages effective January 1, 2002 which are attached to this ACT.


**Attachment**

Rule 5101:1-17-13: Pass-along of SSI income cost-of-living adjustments (COLA) for RSS.


Appendix A - Medicaid Need Standards And Disregards.

Appendix C - Medicare Part B Buy-In Premiums.

Appendix D - of Spousal Impoverishment Standards And Allowances.
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS  
FROM: TOM HAYES, DIRECTOR  
SUBJECT: MEDICAID: STANDARD UTILITY ALLOWANCE  

Reason for change: The standard utility allowance is increased from $244 to $306 effective October 1, 2001.  

Prior policy: The standard utility allowance was $244.  

New policy: Effective October 1, 2001, the standard utility allowance of $306 shall be used when determining the community spouse's monthly income allowance (MIA) in accordance with PAM Section 7526.1.  

Action required: Effective October 1, 2001, the CDJFS shall identify all long term care facility (LTCF) and home and community-based services (HCBS) waiver assistance groups with a community spouse (MA-M) and determine the community spouse’s MIA using the standard utility allowance of $306, when appropriate. Any increase in the MIA shall be effective October 1, 2001. Any decrease in the institutionalized spouse's patient liability due to the increased MIA shall be reported appropriately on the JFS 09400 and JFS 09401 effective October 1, 2001.
ACT 212

Action Change Transmittal Letter No. 212
Food Assistance Change Transmittal No. 21

August 23, 2001

EFFECTIVE DATE: Immediately

PAM CHAPTERS: 3000, 4000, 5000, 7000, and 11000;

FSCH CHAPTER: 3000

OAC Rules: 5101:1-2-30, 5101:1-2-301 and 5101:4-3-06

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
ALL FOOD STAMP CERTIFICATION HANDBOOK HOLDERS

FROM: GREGORY L. MOODY, DIRECTOR

SUBJECT: TRAFFICKING VICTIMS PROTECTION ACT OF 2000

Reason for Change: The Trafficking Victims Protection Act of 2000, Pub. L. No. 106-386, Division A, 114 Stat.1464 (2000), makes adult victims of severe forms of trafficking who have been certified by the U.S. Department of Health and Human Services (HHS) eligible for benefits and services to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act (INA). Victims of severe forms of trafficking who are under age 18 are also eligible for benefits to the same extent as refugees, but do not need to be certified.

Under section 103 (8) of the Act, the term "severe forms of trafficking in persons" means:

(A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or,

(B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

The Trafficking Victims Protection Act aims to combat trafficking through increased law enforcement, to ensure effective punishment of traffickers, to protect victims and to provide Federal and State assistance to victims. This ACT shall contain the procedure for county departments of job and family services (CDJFS) to follow and the acceptable documentation in determining eligibility for benefits.

The Trafficking Victims Protection Act of 2000 was enacted in October 2000, and the regulations explained above are now in effect. The federal guidance on this topic has just been issued and because the regulations are currently in effect we are issuing this ACT/FACT with an immediate effective date. The OAC rules listed on the front page will be placed in departmental clearance.

Prior Policy: None

New Policy: HHS' Office of Refugee Resettlement (ORR) will make certification determinations and issue letters of certification for adult victims of severe forms of trafficking. Children under 18 years of age who are determined to have been subjected to a severe form of trafficking do not need to be certified in order to receive benefits. ORR will issue letters, similar to the adult certification letters, stating that a child is a victim of a severe form of trafficking. Victims of severe forms of trafficking are eligible for benefits and services to the same extent as refugees under section 207 of the INA. Other agencies may issue letters or other documents to victims of severe forms of trafficking. However, only the ORR certification letter or letter for children may be accepted as proof of certification.

Action Required: CDJFS shall follow their regular procedures for refugees and treat the victim of a severe form of trafficking the same as a refugee. However, instead of requiring Immigration and Naturalization Service (INS) documentation, such as the I-94 Arrival/Departure Card, a certification letter or letter for children shall be accepted as proof of status that confers eligibility for benefits. Sample copies of letters are
attached. Please note that the signature and make-up of these letters may change in the coming months.

When a victim of a severe form of trafficking applies for benefits, the CDJFS shall:

(A) **Accept the original certification letter or letter for children in place of the INS documentation.** A photocopy should be retained for the case file and the original returned to the applicant. Victims of severe forms of trafficking are not required to provide any immigration documents to receive benefits.

(B) **Call the trafficking verification line to confirm validity of the certification letter.** The certification letter for adults and the letter for children have a phone number to call to verify their validity. The CDJFS must call the trafficking verification line at **(202) 401-5510** for verification before providing benefits. During the verification phone call, the CDJFS must notify ORR of the benefits for which the victim of trafficking has applied.

**Note:** At this time, the INS Systematic Alien Verification for Entitlements (SAVE) program does not contain information about victims of severe forms of trafficking. ORR is working with INS on this issue and further instructions will be released as soon as possible. Until further notice, the CDJFS shall not contact the SAVE system to confirm eligibility for benefits for victims of a severe form of trafficking.

(C) **Confirm identity.** When confirming identity, many victims of severe forms of trafficking do not yet possess standard identity documents, such as driver's licenses. If confirming identity in these cases is difficult, the CDJFS shall not automatically deny the application, but shall call the trafficking verification line as listed above for assistance.

(D) **Assist in obtaining a social security number.** CDJFS shall not delay, deny, or discontinue assistance to any eligible applicant because he or she does not have a social security number. If an individual is required to provide or apply for a social security number for another benefit program, such as Medicaid, Ohio Works First (OWF) or food stamps; or the victim of severe forms of trafficking does not yet have or is unable to obtain a social security number for work purposes, assistance must be given to these individuals in obtaining non-work social security numbers as delineated below.

The individual will need to present a letter to the Social Security Administration (SSA) from the CDJFS that:

1. is on letterhead;
2. includes the applicant's name;
3. references the non-work reason for which the number is required; and,
4. states that the applicant meets the requirements to receive the benefit except for the social security number.

The letter cannot be a generic application, form letter or photo copy.

(E) **Note the "entry date" for refugee benefits purposes.** Once the certification letter or letter for children is received and the validity of the document is verified by calling the trafficking verification line, the CDJFS shall note the individual's "entry date" for refugee benefit purposes. The entry date is the date of certification. The certification date appears in the body of the certification letter or letter for children.

(F) **Record the expiration date.** The certification letter and the letter for children contain expiration dates. At this time, the expiration dates are eight months from the initial certification date. The CDJFS shall record the expiration date and a reapplication must be completed at the end of the eight-month period. ORR intends to issue follow-up certification letters if individuals continue to meet the statutory certification requirements.

(G) **Issue benefits.** If the applicant meets other program eligibility criteria (e.g., income levels), the individual should receive benefits and services to the same extent as a refugee.

**CRIS-E Processing:** Manual budgeting must be completed. CDJFS shall flat the individuals's eligibility to pass on AEWIF and the assistance group on AEWFT.

**Individuals Without Certification**
If a CDJFS encounters an individual that is believed to meet the definition of a victim of a severe form of trafficking, but the individual has no certification, the CDJFS should call Michael Jewell at (202) 401-4561 or Neil Kromash at (202) 401-5702. If the agency encounters a child believed to have been subjected to a severe form of trafficking and lacks a letter for children, the agency should call Loren Bussert at (202) 401-4732.

This policy will be incorporated in a future Manual Transmittal Letter.

Attachments

the ORR Certification Letter.
the ORR Letter for Children.
TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: GREG MOODY, INTERIM DIRECTOR
SUBJECT: CHANGES TO HEALTHCHEK AND PREGNANCY RELATED SERVICES (PRS) PROGRAM IMPLEMENTATION PLAN (PIP) REQUIREMENTS

Reason for Change: In an effort to clearly and more accurately identify the scope of information required to describe how county departments of job and family services (CDJFS) in Ohio have organized their Healthchek and Pregnancy Related Services (PRS) programs, we are eliminating the requirement that each CDJFS office submit a Program Implementation Plan (PIP) to us.

Prior Policy: Each of the eighty-eight CDJFS offices was required to submit a "Program Implementation Plan (PIP)" which described their local system for implementing both the Healthchek and PRS programs. Most CDJFS offices have submitted a PIP. The purpose of the PIP was to provide documentation of how the CDJFS conducted each program to ensure that the appropriate program services were provided.

New Policy: Effective June 26, 2001, each CDJFS office will no longer be required to submit a PIP. The former PIP requirement can be met by a letter signed by the CDJFS director. This specifically applies to the remaining counties who have not submitted a PIP. Counties who have submitted a PIP can change information in their plan via a letter rather than a formal PIP amendment. The information in the letter should include the following:

A. Healthchek

The CDJFS shall submit in writing, under signature of the CDJFS Director, information regarding where the Healthchek program will be located within the CDJFS, and who has primary responsibility for the program.

(1) The information submitted should include the coordinator's name and who is responsible for informing the following groups of Healthchek eligible consumers:

(a) Newly eligible individuals,
(b) Pregnant women,
(c) Individuals in the custody of a public or private children's service agency,
(d) Hearing, vision, or speech impaired individuals,
(e) Individuals who have difficulty reading, and
(f) Non-English speaking individuals.

(2) In counties with Medicaid-contracting managed care plans (MCPs), the information submitted under the CDJFS director's signature should include plans for coordination of efforts between the CDJFS and the MCPs. This can include written agreements between the CDJFS and the Medicaid-contracting MCPs with provisions for regularly scheduled meetings, as well as other ideas for county and plan coordination.

(3) Any information in the aforementioned sections or any substantial programmatic or budgetary changes to anything in the aforementioned sections shall be submitted in writing under signature of the CDJFS director to:

Bureau of Consumer and Program Support
B. Pregnancy Related Services

The CDJFS shall submit in writing, under signature of the CDJFS Director, information regarding where the Pregnancy Related Services program will be located within the CDJFS, and who has primary responsibility for the program.

(1) The information submitted should include the coordinator's name and who is responsible for performing the following duties:

   (a) Informing women identified as pregnant about the Pregnancy Related Services program,
   (b) Informing women identified as pregnant about the importance of prenatal care,
   (c) Assisting eligible pregnant women in receiving an initial physician visit,
   (d) Tracking identified pregnant women, and
   (e) Submission of data to ODJFS.

(2) The information submitted under the CDJFS Director's signature shall include the types of transportation services available to pregnant women and shall identify:

   (a) Who will provide the transportation services, and
   (b) Whether the agency will provide transportation to infants during the first year of life.

(3) In counties with Medicaid-contracting MCPs, the information submitted under the CDJFS director's signature shall include plans for coordination of efforts between the CDJFS and the MCPs. This can include written agreements between the CDJFS and the Medicaid-contracting MCPs with provisions for regularly scheduled meetings, as well as other ideas for county and plan coordination.

(4) Any information in the aforementioned sections, or any substantial programmatic or budgetary changes to anything in the aforementioned sections shall be submitted in writing under signature of the CDJFS director to:

   Bureau of Consumer and Program Support
   Ohio Department of Job and Family Services
   30 E. Broad Street, 33rd Floor
   Columbus, Ohio 43215-3414

**Action Required:** If a CDJFS has previously submitted a PIP and there have not been any changes since you submitted your PIP (i.e., changes in the way you administer and manage your local Healthchek and PRS programs, or budgetary changes) no action is currently required. If a CDJFS has not previously submitted a PIP to us, or if items have changed from your original PIP, then please submit information in accordance with the above criteria. We will be in touch with counties who have not previously submitted a PIP. A Public Assistance Manual Transmittal Letter (MTL) will be forthcoming which will include revisions to the appropriate Ohio Administrative Code Rules, 5101:1-2-28 and 5101:1-26-04. Additionally, statewide training on the Healthchek and Pregnancy Related Services programs will be offered in the Fall 2001.
**ACT 210**

**Action Change Transmittal No. 210**

EFFECTIVE DATE: July 1, 2001

PAM SECTIONs: 7526 and 7527

OAC RULE: 5101:1-39-221

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: GREGORY L. MOODY, INTERIM DIRECTOR

SUBJECT: MEDICAID: INCREASE IN MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA), FAMILY ALLOWANCE (FA) AND EXCESS SHELTER ALLOWANCE (ESA)

**Reason for change:** Under the Social Security Act's spousal impoverishment provisions, the following Medicaid standards have been increased effective July 1, 2001 based on the federal poverty level (FPL).

For reference purposes, this ACT shows the previous (2000) allowances in parentheses. The increased amounts for 2001 are printed in bold.

<table>
<thead>
<tr>
<th>Allowance</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Monthly Maintenance Needs Allowance (MMMNA)</td>
<td>$1,407</td>
<td>$1,452</td>
</tr>
<tr>
<td>Family Allowance (FA) 1/3 of MMMNA</td>
<td>$469</td>
<td>$484</td>
</tr>
<tr>
<td>Excess Shelter Allowance (ESA)</td>
<td>$423</td>
<td>$436</td>
</tr>
</tbody>
</table>

**Action required:** A review of all long term care facility (LTCF) and home and community-based services (HCBS) assistance groups with a community spouse must be completed. The CDJFS must recalculate the community spouse’s MIA using the above allowances. These cases (MA-M) can be identified utilizing the caseload query system available on CRIS-E. No case alerts will be issued and there will not be a mass change done by CRIS-E.

Effective July 1, 2001, all new applicants must have their eligibility determined using the above revised allowances.

Remove and obsolete Appendix D of Public Assistance Manual Chapter 7000 and replace with the attached corresponding page revised effective July 1, 2001.
April 6, 2001

EFFECTIVE DATE: April 1, 2001

PAM CHAPTER: 7000


TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: JO ANN DAVIDSON, DIRECTOR
SUBJECT: MEDICAID: CHANGES OF MEDICAID NEED STANDARDS DUE TO 2001 FEDERAL POVERTY LEVEL INCREASE

On February 16, 2001, the Department of Health and Human Services provided the updated federal poverty level (FPL) guidelines which are being increased due to the price increase as measured by the Consumer Price Index. The following Medicaid standards and allowance are affected by these changes:

1) Qualified Medicare Beneficiary (QMB)
2) Specified Low-Income Medicare Beneficiary (SLMB)
3) Qualified Individuals-1 (QI-1)
4) Qualified Individuals-2 (QI-2)
5) Qualified Working Disabled Individual (QWDI)

For reference purposes, this ACT shows the previous (2000) standards and allowances in parenthesis. The increased amounts for 2001 are printed in bold.

The table below contains Medicaid standards and allowances that are affected by the changes mentioned above:

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SINGLE</th>
<th>COUPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUALIFIED MEDICARE BENEFICIARY (QMB) 100% of FPL</td>
<td>$716 ($696-2000)</td>
<td>$968 ($938-2000)</td>
</tr>
<tr>
<td>SPECIAL LOW-INCOME MEDICARE BENEFICIARY (SLMB) 120% of FPL</td>
<td>$859 ($835-2000)</td>
<td>$1161 ($1125-2000)</td>
</tr>
<tr>
<td>QUALIFIED INDIVIDUALS-1 (QI-1) 135% of FPL</td>
<td>$967 ($940-2000)</td>
<td>$1307 ($1266-2000)</td>
</tr>
<tr>
<td>QUALIFIED INDIVIDUAL-2 (QI-2) 175% of FPL</td>
<td>$1253 ($1218-2000)</td>
<td>$1694 ($1641-2000)</td>
</tr>
<tr>
<td>QUALIFIED WORKING DISABLED INDIVIDUAL (QWDI) 200% of FPL</td>
<td>$1432 ($1392-2000)</td>
<td>$1935 ($1875-2000)</td>
</tr>
</tbody>
</table>

ACTION REQUIRED:
1) The exemption of the January 1, 2001 cost-of-living increases received by QMB, SLMB, QI-1, and QI-2 and QWDI assistance groups ceases effective April 1, 2001. CRIS-E will complete a mass change
effective April 1, 2001 to update MA-L and MAUS budgets to include the COLA increases on these cases.

2) If the CDHS becomes aware of any assistance group denied or terminated due to the use of the previous needs standards and allowances which have been increased in this ACT, the CDJFS shall redetermine eligibility using the current needs standards and allowances. Adverse actions cannot be implemented until the CDJFS provides appropriate notice in accordance with Chapter 5101:6-2 of the Ohio Administrative Code (OAC).

**INSTRUCTIONS:**
Remove and file as obsolete, in the appendix to Chapter 7000, Appendix B. Replace with the updated version of Appendix B.
EFFECTIVE DATE: February 1, 2001


TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS
FROM: JOANN DAVIDSON, DIRECTOR
SUBJECT: MEDICAID: CHANGE IN HEALTHY START, HEALTHY FAMILIES NEED STANDARD DUE TO FEDERAL POVERTY LEVEL INCREASES

Reason for change: On February 16, 2001, the Department of Health and Human Services issued the updated federal poverty level (FPL) guidelines which are being increased due to the price increase as measured by the Consumer Price Index. The Healthy Start, Healthy Family standards are affected by this change.

Prior Policy: Based on the 2000 FPL guidelines, the Healthy Start Standards are as follows:

100% Healthy Families Std.
1 $696.00
2 938.00

150% Healthy Start Std.
1 $1044.00
2 1047.00

200% Healthy Start Std.
1 $1392.00
2 1876.00

New Policy: Effective February 1, 2001, the CDJFS shall determine initial and ongoing eligibility for Healthy Start using the following standards (the 100% Healthy Start standard is no longer used to determine eligibility.) The Healthy Families standard has been increased to 100% of the FPL.

100% Healthy Families Std.
1 $716.00
2 968.00
3 1220.00
4 1471.00
5 1723.00
6 1975.00

150% Healthy Start Std.
1 1074.00
2 1452.00
3 1829.00
4 2207.00
5 2584.00
**200% Healthy Start Std.**

1 1432.00
2 1935.00
3 2439.00
4 2942.00
5 3445.00
6 3949.00

**Action Required:** Effective February 1, 2001, the CDJFS shall use the current standards contained in this ACT to determine eligibility for Healthy Start and Healthy Families. If the CDJFS becomes aware of any Healthy Start or Healthy Families assistance groups denied or terminated due to the use of the previous standards, the CDJFS shall determine eligibility using the current need standards. The current need standards can be found on CRIS-E reference table THST.

Mass change will not be run against Healthy Start, Healthy Family assistance groups. When ED/BC is requested for any case with these assistance groups, the correct standard will appear on the budget screens. The CDJFS shall rerun any cases which were inappropriately denied due to the use of the previous standards.
March 14, 2001

EFFECTIVE DATE: January 1, 2001

PAM CHAPTER/OAC:

6000 (OAC 5101:1-17-13)


TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: JACQUELINE ROMER-SENSKY, DIRECTOR

SUBJECT: 2001 SOCIAL SECURITY COST OF LIVING ADJUSTMENTS (COLA)

SUPPLEMENTAL SECURITY INCOME (SSI) BENEFIT INCREASE

SOCIAL SECURITY BENEFIT INCREASE

RAILROAD RETIREMENT BENEFIT INCREASE

SPOUSAL IMPOVERISHMENT STANDARDS

Effective January 1, 2001 there is a 3.5% cost-of-living adjustment (COLA) for SSI, Social Security, and Railroad Retirement benefits. The Medicare Part B premium is also increasing to $50.00 per month. For reference, this ACT shows the previous (2000) standards and payment amounts in parenthesis as well as the increased amounts for 2001 which are printed in bold.

SSI Increase:

For SSI, the $30 payment to institutionalized individuals will remain the same. The benefit amounts, including increases for other individuals will be:

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>(2000)</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>($512)</td>
<td>$530</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>($769)</td>
<td>$796</td>
</tr>
<tr>
<td>Supplement for an essential person in an</td>
<td>($257)</td>
<td>$266</td>
</tr>
<tr>
<td>independent living arrangement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual living in the home of another</td>
<td>($341.34)</td>
<td>$353.34</td>
</tr>
<tr>
<td>Couple living in the home of another</td>
<td>($512.67)</td>
<td>$530.67</td>
</tr>
<tr>
<td>Supplement for an essential person living in the home of another</td>
<td>($170.67)</td>
<td>$177.34</td>
</tr>
</tbody>
</table>

SSI continues to use a retrospective budgeting method in computing monthly benefit payments.

Medicare premium:

MEDICARE PART B PREMIUM
Medicaid need standards:
Effective January 1, 2001 the Medicaid need standards are increased as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>($444)</td>
<td>$460</td>
</tr>
<tr>
<td>Couple living own household</td>
<td>($769)</td>
<td>$796</td>
</tr>
<tr>
<td>Individual living in household of another</td>
<td>($296)</td>
<td>$307</td>
</tr>
<tr>
<td>Couple in household of another</td>
<td>($512)</td>
<td>$530</td>
</tr>
</tbody>
</table>

**Special income level:**

<table>
<thead>
<tr>
<th>Special Income Level</th>
<th>(2000)</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household)</td>
<td>($1536)</td>
<td>$1590</td>
</tr>
</tbody>
</table>

PAM Chapter 7000 (Appendix D) has been updated to reflect this change.

**Home and Community-Based Services (HCBS) Waivers:**

<table>
<thead>
<tr>
<th>Home and Community-Based Services Waivers</th>
<th>(2000)</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special individual maintenance needs allowance used to determine patient liability</td>
<td>($1001)</td>
<td>$1036</td>
</tr>
</tbody>
</table>

**Disregard of Title II COLA:**

The Title II COLA is disregarded for QMB, SLMB, QI-1 and QI-2 assistance groups for January, February, and March 2001 only. These assistance groups shall have the COLA applied in the financial eligibility determination effective April 1, 2001. For QMB/SLMB/Medicaid dually eligible assistance groups, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The gross amount of an individual's Title II benefits should be entered on AEFMI. CRIS-E will deduct the 3.5% COLA.

In February 2001, the federal poverty level (FPL) will be increased. This will cause an increase in the QMB and SLMB standards effective April 1, 2001. Information regarding the necessary CDJFS activity for the April 2001 change will be provided in the near future.

**RSS Assistance Groups:**

The SSI COLA is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS assistance groups:

<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td></td>
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</tbody>
</table>


### Maximum SSI Benefit

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit 2000</th>
<th>Benefit 2001</th>
<th>COLA 2000</th>
<th>COLA 2001</th>
<th>Total Disregard to Date 2000</th>
<th>Total Disregard to Date 2001</th>
</tr>
</thead>
</table>

PAM Chapter 6000 (OAC 5101:1-17-13) will be updated within a future Manual Transmittal Letter.

### Black Lung Benefit Increase:

The Black Lung benefit is anticipated to increase effective February 2001; however, the percentage of increase is not available at this time. Information regarding the Black Lung benefit increase and necessary CDJFS activity will be provided as soon as the percentage of increase is available.

### Increase in Spousal Impoverishment Standards:

The Consumer Price Index (CPI) will increase by 3.5%. Effective January 1, 2001 the following spousal impoverishment standards are increased as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum community spouse resource allowance</td>
<td>($16,824)</td>
<td>$17,400</td>
</tr>
<tr>
<td>Maximum community spouse resource allowance</td>
<td>($84,120)</td>
<td>$87,000</td>
</tr>
<tr>
<td>Maximum monthly maintenance needs allowance (CAP)</td>
<td>($2,103)</td>
<td>$2,175</td>
</tr>
</tbody>
</table>

The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2001 based on the federal poverty level.

### CRIS-E:

CRIS-E performed a mass change over the weekend of November 25, 2000 to update SSI, Social Security, and Railroad Retirement cost-of-living increases and the increased Medicaid need standards effective January 1, 2001. The $30 SSI payment to institutionalized individuals remains the same.

To the extent possible, pending assistance groups should have been authorized prior to the mass change. Otherwise, the mass change action by-passed them. CRIS-E does not automatically perform a mass change for cases in fiated status or assistance groups with spenddown amounts.

CRIS-E will disregard the COLA increases for QMB and SLMB assistance groups until the cutoff for April 2001 benefits.

CRIS-E ALERTS were sent for all assistance groups that were bypassed by mass change.

### LTCF Assistance Groups:

Instructions for redetermining any change in the patient liability for LTCF assistance groups are explained in Public Assistance Letter (PAL) No. 868-A dated December 24, 1996.

Two reports were issued to the CDJFS. The first report (BON003-R001) identifies each individual who resides in a long term care facility. This report is for CDJFS information only. The second report (BON003-R002) is a summary of all individuals by LTCF. This report can be annotated and sent to the LTCF.

The cutoff for prior notice was December 14, 2000. Any adverse notices regarding an increase in the patient liability after that date are to be effective February 1, 2000. **Retroactive adjustments for periods prior to**
the expiration of the prior notice of an increase in the patient liability are not correct and the CDJFSs are not authorized to initiate them.

Prior Notice of Adverse Action:
All assistance groups adversely affected by the increased benefit amounts shall be provided with written notice of the proposed action. CRIS-E cases updated by the mass change shall be provided appropriate notice through a computer-generated notice. Assistance groups bypassed during mass change shall be provided appropriate notice from the CDJFS in accordance with OAC 5101:6-2-04.

The ODHS 4065, "Prior Notice of Right to a State Hearing," or appropriate CRIS-E notice shall contain the following language.

THE REASON FOR THIS PROPOSED ACTION . . . "This action is necessary because federal regulations have provided you, your spouse, or a family member with an increase in Supplemental Security Income (SSI), Social Security, or Railroad Retirement benefits. Public Assistance Manual Sections 3000 (OAC 5101:1-23-020), 5000 (OAC 5101:1-5-40) 7436 (5101:1-39-16), and II000 (OAC 5101:1-40-20) require that this income be counted in determining eligibility for assistance."

An adverse action cannot be taken until 15 days have elapsed from the date of issuing the notice of adverse action. After the expiration of the 15-day prior notice period, the proposed action shall be implemented if a hearing on the proposed action is not requested.

If a hearing request is made within the 15-day prior notice period, assistance must continue until it is determined at the hearing that the sole issue is one of state policy or until the hearing decision is rendered. All appeals of adverse actions resulting from increased amounts must be forwarded to the State Hearings Section. If assistance is continued during the pendency of the hearing and the decision is against the assistance group, a collectible overpayment may occur.

Instructions:
In the Appendix to Chapter 7000, remove and file as obsolete Appendices A (Rev. 5/00), C (Rev. 1/00), and D (Rev. 10/00) and replace with the corresponding pages effective January 1, 2001 which are attached to this ACT.

Attachments:
Chapter 7000, Appendix A
Chapter 7000, Appendix C
Chapter 7000, Appendix D
EFFECTIVE DATE: MARCH 1, 2001

PAM SECTIONS: 11560 - 11565


TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: JACQUELINE ROMER-SENSKY, DIRECTOR

SUBJECT: OWF AND COVERED FAMILIES AND CHILDREN (CFC) MEDICAID: IMMEDIATE RESCISSION OF THE NON-RECURRING LUMP SUM PAYMENTS POLICY

Reason for Change: An administrative decision has been made to rescind the policy regarding the treatment of nonrecurring lump-sum payments. This policy change is effective March 1, 2001 and affects any OWF or CFC Medicaid (including Healthy Start) assistance group that receives a non-recurring lump-sum payment, as well as any OWF or CFC Medicaid assistance group that is currently ineligible, due to prior receipt of a non-recurring lump-sum payment for which a period of ineligibility was computed. All previous periods of ineligibility for OWF and CFC Medicaid assistance groups due to prior receipt of a non-recurring lump-sum payment end as of February 28, 2001.

Prior Policy: Receipt of a non-recurring lump-sum payment by an OWF and/or a CFC Medicaid assistance group was counted as income in the month received and apportioned toward future months. This calculation often resulted in a period of ineligibility, meaning that the assistance group was ineligible to participate in OWF and/or CFC Medicaid for a certain number of months, depending upon the amount of the non-recurring lump-sum payment that was received. Receipt of a non-recurring lump-sum payment by a DA assistance group was counted as income in the month received and as personal property in the months thereafter. The lump sum became a resource in the month following the month of receipt and was treated in accordance with the provisions set forth in rule 5101:1-5-30.

New Policy: Effective March 1, 2001, receipt of a non-recurring lump-sum payment by a member of an OWF and/or CFC Medicaid assistance group shall not result in the calculation of a period of ineligibility. The lump-sum payment shall be excluded from the determination of continued eligibility for OWF and CFC Medicaid.

Action Required: No desk review is required for OWF, CFC Medicaid or DA.

OWF AND CFC MEDICAID:

Effective March 1, 2001, all non-recurring lump-sum payments received by an OWF and/or a CFC Medicaid assistance group shall be considered to be income in the month received, and a resource thereafter. This means that the receipt of the nonrecurring lump sum payment in a month most often will not affect continued eligibility for OWF and CFC Medicaid in that month, because an assistance group that is eligible on the first day of the month is eligible for the entire month. Changes in income during a month that affect the assistance group's future eligibility are used in calculating the future months' eligibility. Because the non-recurring lump-sum payment is not a recurring source of income, it should not be used in determining prospective eligibility. Since there is no resource limit for the OWF program, treatment of the lump-sum payment after the month of receipt as a resource will not affect OWF eligibility.

No calculation of a future period of ineligibility for OWF or CFC Medicaid shall be made based on receipt of the non-recurring lump sum payment.

When an OWF or CFC Medicaid assistance group for whom a prior period of ineligibility was computed reapply, the assistance group will pass, and if all other eligibility requirements are met, the assistance group(s) shall be approved and authorized. In those situations where the case is being rerun for another reason, OWF and CFC Medicaid assistance groups will pass; however, the OWF and CFC assistance groups
should not be authorized without a new application. Instead, the county is advised to notify the assistance group advising that potential eligibility for OWF and/or CFC Medicaid exists, and that they may reapply for these benefits at the CDJFS.

**DA**

DA policy is not changing. The policy governing receipt of non-recurring lump-sum payment in the DA program was formerly contained in rule 5101:1-23-07. With the rescission of rule 5101:1-23-07, rule 5101:1-5-40 has been amended to state that a non-recurring lump-sum payment is considered income in the month received and a resource thereafter.

**FOOD STAMPS**

Food stamp policy is not changing. In accordance with rule 5101: 4-4-07, for food stamps, nonrecurring lump-sum payments are to be counted as resources in the month received, unless specifically excluded from consideration as a resource by other Federal laws. For example, all resources of an SSI or OWF recipient are excluded.

**CRIS-E PROGRAMMING CHANGES**

The AERLS screen has been modified to prevent a period of ineligibility from being computed for OWF and CFC Medicaid assistance groups as of March 1, 2001. The AERLS screen will predisplay "N" on the "ADC/ADC RELATED MA:" field. The "N" will be protected and cannot be changed by the user.

The result of this screen change is that any time a case is rerun on or after March 1, 2001, it will prevent the entry of lump sum information for OWF and CFC Medicaid purposes so that a period of ineligibility will not be computed, and any previous period of ineligibility will also be ended. While the end date for a prior period of ineligibility reflected on AEOIE will reflect the original ineligibility dates, the assistance group's eligibility for OWF and/or CFC Medicaid will not be affected by the previously determined period of ineligibility, i.e., if the assistance group is otherwise eligible for OWF and/or CFC Medicaid, the assistance group will pass and show as eligible.
October 6, 2000

Effective Date: October 1, 2000

PAM Section: 528

OAC Rule: 5101:1-39-221

TO: ALL PUBLIC ASSISTANCE MANUAL HOLDERS

FROM: JACQUELINE ROMER-SENSKY, DIRECTOR

SUBJECT: MEDICAID: STANDARD UTILITY ALLOWANCE

Reason for Change: The standard utility allowance is increased from $241 to $244 effective October 1, 2000.

Prior Policy: The standard utility allowance was $241.

New Policy: Effective October 1, 2000, the standard utility allowance of $244 shall be used when determining the community spouse's monthly income allowance (MIA) in accordance with PAM Section 7526.1.

Action Required: Effective October 1, 2000, the CDJFS shall identify all nursing facility (NF), ICF-MR, and home and community-based services (HCBS) assistance groups with a community spouse (MA-M) and determine the community spouse's MIA using the standard utility allowance of $244 when appropriate. Any increase in the MIA shall be effective October 1, 2000. Any decrease in the institutionalized spouse's patient liability due to the increased MIA shall also be effective October 1, 2000.
Effective January 1, 2000 there is a 2.4% cost-of-living adjustment (COLA) for SSI, Social Security, and Railroad Retirement benefits. The Medicare Part B premium has not been increased from $45.50 per month. For reference, this ACT shows the previous (1999) standards and payment amounts in parenthesis as well as the increased amounts for 2000 which are printed in bold.

**SSI Increase:**
For SSI, the $30 payment to institutionalized individuals will remain the same. The benefit amounts, including increases for other individuals will be:

<table>
<thead>
<tr>
<th>SSI PAYMENT AMOUNTS</th>
<th>(1999)</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual living independently</td>
<td>($500)</td>
<td>$512</td>
</tr>
<tr>
<td>Couple living independently</td>
<td>($751)</td>
<td>$769</td>
</tr>
<tr>
<td>Supplement for an essential person in an independent living arrangement</td>
<td>($250)</td>
<td>$257</td>
</tr>
<tr>
<td>Individual living in the home of another</td>
<td>($333.34)</td>
<td>$341.34</td>
</tr>
<tr>
<td>Couple living in the home of another</td>
<td>($500)</td>
<td>$512.67</td>
</tr>
<tr>
<td>Supplement for an essential person living in the home of another</td>
<td>($166.67)</td>
<td>$170.67</td>
</tr>
</tbody>
</table>

SSI continues to use a retrospective budgeting method in computing monthly benefit payments.

**Medicare premium:**
MEDICARE PART B PREMIUM  ($45.50/1999)  $45.50 / 2000

**Medicaid need standards:**
Effective January 1, 2000 the Medicaid need standards are increased as follows:
MEDICAID NEED STANDARDS

<table>
<thead>
<tr>
<th></th>
<th>(1999)</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual in own household</td>
<td>($433)</td>
<td>$444</td>
</tr>
<tr>
<td>Couple living own household</td>
<td>($751)</td>
<td>$769</td>
</tr>
<tr>
<td>Individual living in household of another</td>
<td>($289)</td>
<td>$296</td>
</tr>
<tr>
<td>Couple in household of another</td>
<td>($500)</td>
<td>$512</td>
</tr>
</tbody>
</table>


Special income level:

SPECIAL INCOME LEVEL

| Institutionalized/HCBS waiver (300% of current SSI benefit for an individual living in his own household) | ($1500/1999) | $1536/2000 |

PAM Chapter 7000 (Appendix D) has been updated to reflect this change.

Home and Community-Based Services (HCBS) Waivers:

HOME and COMMUNITY-BASED SERVICES WAIVERS

| Special individual maintenance needs allowance used to determine patient liability | ($977/1999) | $1001/2000 |

Disregard of Title II COLA:

The Title II COLA is disregarded for QMB and SLMB assistance groups for January, February, and March 2000 only. QMB and SLMB assistance groups shall have the COLA applied in the financial eligibility determination effective April 1, 1999. For QMB/Medicaid dually eligible assistance groups, the COLA is only disregarded for the QMB/SLMB financial eligibility determinations. The gross amount of an individual’s Title II benefits should be entered on AEFMI. CRIS-E will deduct the 2.4% COLA.

In February 2000, the federal poverty level (FPL) will be increased. This will cause an increase in the QMB and SLMB standards effective April 1, 2000. Information regarding the necessary CDHS activity for the April 2000 change will be provided in the near future.

RSS Assistance Groups:

The SSI COLA is disregarded for the Residential State Supplement (RSS) program. The following chart provides the SSI COLA and the total to-date amounts to be disregarded when determining financial eligibility and cash payments for RSS assistance groups:

PASS-ALONG OF SSI COLA

<table>
<thead>
<tr>
<th></th>
<th>Maximum SSI benefit</th>
<th>COLA</th>
<th>Total disregard to date</th>
</tr>
</thead>
</table>
Black Lung Benefit Increase:
The Black Lung benefit is anticipated to increase effective February 2000; however, the percentage of increase is not available at this time. Information regarding the Black Lung benefit increase and necessary CDHS activity will be provided as soon as the percentage of increase is available.

Increase in Spousal Impoverishment Standards:
The Consumer Price Index (CPI) will increase by 2.6%. Effective January 1, 2000 the following spousal impoverishment standards are increased as follows:

| Maximum community spouse resource allowance | ($81,960 / 1999) | $84,120 / 2000 |
| Maximum monthly maintenance needs allowance (CAP) | ($2,049 / 1999) | $2,103 / 2000 |

The minimum monthly maintenance needs allowance, excess shelter allowance and the family allowance will be revised effective July 1, 2000 based on the federal poverty level.

CRIS-E:
CRIS-E will perform a mass change over the weekend of November 26, 1999 to update SSI, Social Security, and Railroad Retirement cost-of-living increases and the increased Medicaid need standards effective January 1, 2000. The $30 SSI payment to institutionalized individuals remains the same.

Any pending assistance groups should be authorized, if possible, or the mass change will bypass them. CRIS-E will not automatically perform the mass change for cases in fiated status or assistance groups with spenddown amounts.

CRIS-E will disregard the COLA increases for QMB and SLMB assistance groups until the cutoff for April 2000 benefits.

CRIS-E ALERTS will be sent for all assistance groups that are bypassed by mass change.

LTCF Assistance Groups:
Instructions for redetermining any change in the patient liability for LTCF assistance groups are explained in Public Assistance Letter (PAL) No. 868-A dated December 24, 1996.

Two reports will be issued to the CDHS. The first report (BON003-R001) will identify each individual who resides in a long term care facility. This report is for CDHS information only. The second report (BON003-R002) is a summary of all individuals by LTCF. This report can be annotated and sent to the LTCF.

The cutoff for prior notice is December 14, 1999. Any adverse notices regarding an increase in the patient liability after that date are effective February 1, 2000. **Retroactive adjustments for periods prior to the expiration of the prior notice of an increase in the patient liability are not correct.**

Prior Notice of Adverse Action:
All assistance groups adversely affected by the increased benefit amounts shall be provided with written notice of the proposed action. CRIS-E cases updated by the mass change shall be provided appropriate notice through a computer-generated notice. Assistance groups bypassed during mass change shall be provided appropriate notice from the CDHS in accordance with OAC 5101:6-2-04.

The ODHS 4065, "Prior Notice of Right to a State Hearing," or appropriate CRIS-E notice shall contain the following language.

**THE REASON FOR THIS PROPOSED ACTION** . . . "This action is necessary because federal regulations have provided you, your spouse, or a family member with an increase in Supplemental Security Income (SSI), Social Security, or Railroad Retirement benefits. Public Assistance Manual Sections 3000 (OAC 5101:1-23-020), 5000 (OAC 5101:1-5-40) 7436 (5101:1-39-16), and 11,000 (OAC 5101:1-40-20) require that this income be counted in determining eligibility for assistance."
An adverse action cannot be taken until 15 days have elapsed from the date of issuing the notice of adverse action. After the expiration of the 15-day prior notice period, the proposed action shall be implemented if a hearing on the proposed action is not requested.

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